STRENGTHENING FAMILIES: THE RELATIONSHIP BETWEEN HOPE, SPIRITUALITY, RESILIENCE, AND ATTACHMENT AMONG PARENTS FOLLOWING ADVERSE CHILDHOOD EXPERIENCES

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BY

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DEDICATION

There is nothing more important than the intergenerational impact of family. This is first dedicated to my late parents, Louie and Juanita Wilkinson, who modeled a lifelong love for learning and truly walked the walk of Christ-like love. Next, this is dedicated to my children who have taught me, and continue to teach me, the importance of loving and being loved. And, last, this is dedicated to every parent who has struggled through adversity and wants a better life for their children.

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ABSTRACT

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STRENGTHENING FAMILIES: THE RELATIONSHIP BETWEEN HOPE, SPIRITUALITY, RESILIENCE, AND ATTACHMENT AMONG PARENTS FOLLOWING ADVERSE CHILDHOOD EXPERIENCES

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Faith-based ministries and non-profit organizations focused on strengthening families and family preservation may wrap services around families, but may underestimate the intergenerational impact of childhood adversity and trauma on the family system. Understanding the neurological, educational, and health outcomes as a result of adverse childhood experiences is key to developing evidenced-based, therapeutic programs to best assist clients in strengthening the internal protective factors of hope, resilience, spirituality, and attachment, in an effort to avoid harmful intergenerational beliefs, attitudes, actions, and habits following their exit from programs. The aim of this online, mixed methods study was to examine the relationship between adverse childhood experiences and the internal protective factors of hope, resilience, spirituality, and attachment, through the lens of attachment theory (Bowlby, 1957) and resiliency theory (Walsh, 1996).

The data collected in this study were obtained through participants in the Buckner Children and Family Services, Inc. Family Pathways Program. Participants were single parents, enrolled in a higher education program, between the ages of 18-45 years of age, male or female, and a resident at one of eight Family Pathways locations in Texas. The

voluntary, confidential study was accessed online and consisted of questions from: a demographic questionnaire; the Adverse Childhood Experiences Questionnaire (ACES-Q), the Adult Hope Scale (AHS); the Resilience Scale (RS); the Spiritual Well-Being Scale (SWBS); and the Revised Adult Attachment Scale (RAAS). In addition, five qualitative questions, one after each of the quantitative inventories, gathered additional insight from the participant's viewpoint and responses were coded into themes. Pearson product-moment correlation analysis was used to examine the relationship between adversity and the internal protective factors of hope, resilience, spirituality, and attachment.

A response rate of 38% was achieved from 134 possible participants. Yet, their demographic variables were representative of the overall program demographics. The respondents scored higher than the national average (12.5%) in overall ACEs scores with 60.8% of the population scoring 4 or more. The results of the quantitative data revealed that those with higher ACEs scores also had increased attachment anxiety. In the domain of ACEs Abuse, those who suffered physical, verbal, or sexual abuse as a child had a weak to moderate negative correlation with Hope, the subscale of Hope Pathway, Spirituality, the subscale of Spirituality Existential, and a strong negative correlation with the subscales of Attachment Depend and Attachment Close. Those who experienced greater Household Dysfunction correlated positively with Resilience. Qualitative data identified strength-based themes of responsibility for self and others, sense of community, and personal relationship with God. Adversity-based themes included feeling

unprotected and alone (primarily related to childhood Household Dysfunction), having few choices, and a lack of trust in self, others, and religious institutions.

The implications of the data yielded from this study encourage counseling programs to focus on promotive factors in order to build on strengths, such as building attachment security, increasing the capacity for resilience and hope, increasing opportunities to engage positively with others, and psychoeducational programs aimed at providing trauma-informed interpersonal and intrapersonal awareness and best parenting practices.

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CHAPTER I

INTRODUCTION

Not only are people collectively interconnected to one another but individually intraconnected as well. What impacts the body, impacts the mind (van der Kolk, 2014). What impacts the spirit, impacts one's health (Koenig, 2012). Dr. Martin Luther King, Jr. (1963), while in jail in Birmingham, Alabama, wrote and later expanded on the topic in a commencement ceremony at Oberlin College in 1965:

> In a real sense all life is inter-related. All men are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly. I can never be what I ought to be until you are what you ought to be, and you can never be what you ought to be until I am what I ought to be...This is the inter-related structure of reality (pp. 2-3).

Dr. King's words express the inter- and intra-connectedness of mankind.

Over the last several decades, there has been tremendous focus on trauma, the treatment of trauma, and trauma informed-care, ranging from early intervention and prevention to residential treatment for the treatment of significant mental, emotional, and physical impacts of early childhood adversity and trauma (van der Kolk, 2014). While the American Psychological Association (2017a) describes trauma as an emotional and physical event that creates distress, Felitti and Anda, authors of the Adverse Childhood Experiences Study Questionnaire (ACES-Q; Felitti et al., 1998), redefined the significant

impact of traumatic events from the perspective of abuse, neglect, and household dysfunction and the ongoing impact of that trauma into adulthood. Understanding how the body, the mind, and the spirit are interrelatedly impacted by adversity is critical for professionals serving families. As the ACES has confirmed, what happens in childhood impacts the individual throughout the lifespan (van der Kolk, 2014).

Yet, in the United States, while research findings suggest the outcomes for adults who have faced abuse, neglect, household dysfunction and poverty as children, many federal and state programs have faced budget cuts since the recession in 2008. According to the Center on Budget and Policy Priorities (2017), higher education funding has dropped 16-30% per student since 2008. Future youth funding may be cut by 7% as well as a reduction in Head Start programs for 2018 (Center on Budget and Policy Priorities, 2017). The Children's Health Insurance Program (CHIP) has been cut by 21%, including other health programs for children, such as Emergency Medical Services for Children, Universal Newborn Hearing Screens, and the Supplemental Nutrition Assistance Program (SNAP; Center on Budget and Policy Priorities, 2017). Housing programs, such as the National Housing Trust Fund, Homeless Assistance Grants, Tenant Rental Assistance Programs and Low Income Heating Assistance Programs face elimination or have been eliminated (National Alliance to End Homelessness, 2017). On the other hand, an increase in stress related to finances, employment, and relationships can disrupt parenting, causing negative parent-child interactions, and increasing the potential for abuse and/or neglect (Webster-Stratton, 2011).

It is important to note that adversity has a dose-response, graded relationship with poor outcomes (Felitti et al., 1998). The higher the ACEs score, the greater risk to the individual. Adults with an ACEs score of four or greater are at greater risk for substance abuse, unemployment, mental health issues, domestic violence and lower educational attainment (Metzler, Merrick, Klevens, Ports, & Ford, 2017). As Adverse Childhood Experiences scores increase, risk factors across multiple domains increase (Felitti et al., 1998; Metzler et al., 2017). Overall, ACEs are common. Approximately a third of those surveyed in the original Kaiser Permanent study experienced no adversity, meaning more than two-thirds did (Felitti et al., 1998). Of those who reported Adverse Childhood experiences, 26% experienced one, 15.9% experienced two, and 9.5% experienced three. Most surprising was that 12.5% of that sample experienced four or more ACEs, placing them at greater risk for disease, substance/alcohol abuse, domestic violence, and early death, including suicide (Dube et al., 2001). Those with ACEs scores of 7 or higher are more likely to die 20 before their peers with lower or non-existent ACEs scores (Dube et al., 2001).

Numerous studies followed the Kaiser Permanent study, utilizing the Adverse Childhood Experiences Questionnaire (Anda et al., 2006; Anda et al., 2009; Ports, Ford, & Merrick, 2016). The original study had been conducted on a low risk population of educated, white adults with access to healthcare. Follow up studies began to paint a bleak picture when using high-risk populations (Flaherty et al., 2013; Halfon, Larson, Son, Lu, & Bethell, 2017; Soares et al., 2016). In one follow up study of 933 high-risk adolescents,

90% of those surveyed had experienced at least one adverse experience by age 14 (Flaherty et al., 2013). Studies were also being conducted on children who had been exposed to chronic stress and trauma, including children who were in foster care (Hambrick, Oppenheim-Weller, N'ze, & Taussig, 2016). The greatest challenge emerging from research on trauma was identifying the early adversity for the sake of prevention and treatment, with the awareness that the individual may not be able to recall the memories of their adversity (van der Kolk, 2014). In addition, researchers show an intergenerational impact of adverse experiences: what happens to one generation predicts the ACEs score of the second generation (Anda et al., 2009).

Protective factors such as resilience, spirituality, attachment, and hope can combat negative outcomes (Björkenstam, Kosidou, & Björkenstam, 2016; Domhardt, Münzer, Fegert, & Goldbeck, 2015; Werner, 2005). Through the Center for the Study of Social Policy, Browne (2014) identified five protective factors for strengthening family systems: parenting resilience, social connections, concrete supports (financial assistance, housing, for example), knowledge of parenting and child development, and social and emotional competence of children. Faith-based, social service organizations may be able to provide the protective factors of concrete supports, parenting education and targeting the social and emotional competence of children. However, assisting program participants with internal protective factors, such as hope, spirituality, attachment, and resilience, becomes more difficult, yet vital to the healing of ACEs and reducing the intergenerational impact of adversity (Browne, 2014; Koenig, 2012).

Statement of the Problem

Faith-based, non-profit social service organizations are faced with challenges in the years ahead as the federal and state governments decrease services while the risks for adverse childhood experience will likely remain steady, as there has been no reduction in the number of ACEs reported since 1997 (Metzler et al., 2017). In addition, how faith-based, non-profit social service organizations provide services may become more critical. There is a fundamental need for holistic services aimed at reducing risks to vulnerable parents and children while increasing protective factors that will assist in strengthening and preserving families (Browne, 2014). The Center for the Study of Social Policy is a collaborative effort of multiple government and social organizations seeking to strengthen families. Through this collaborative effort, Browne (2014) developed The Strengthening Families Approach and Protective Factors framework, listing five protective factors: parental resilience; concrete support, such as food, clothing and shelter, to help reduce stress; social connections; educational programming to help build parenting skills and an understanding of child development; and early identification of children's needs to build social and emotional competency in children (Browne, 2014).

Organizations may be able to assist in stabilizing the family structure through housing, financial assistance, parent education, and early childhood programs that assess and treat emotional and social competency in children. However, building resilience, hope, and spirituality are protective factors that are internally motivated (Sabina & Banyard, 2015). From a clinical perspective, understanding how the client perceives their

strengths in the face of adversity is a significant step in overcoming adversity and the impact of one's adverse experiences (Sabina & Banyard, 2015; van der Kolk, 2014). Numerous medical research studies have confirmed the importance of spirituality, religiosity and hope in the face of adversity as protective factors (Duggal, Sacks-Zimmerman, & Liberta, 2016; Koenig, 2012). Given the trajectory of negative outcomes for those who have faced ACEs, the challenge facing clinical professionals is how to target and enhance internal protective factors to change the trajectory (van der Kolk, 2014).

Statement of the Purpose

This researcher investigated the internal protective factors of hope, attachment, resilience, and spirituality identifying the clinical needs and areas of clinical growth of parents participating in a nonprofit program. Further study was needed on how ACEs may impact internal protective factors and whether there is a relationship between ACEs scores and one's ability to have hope, maintain faith and draw upon one's resilience. Utilizing the Strengthening Families Approach and Protective Factors Framework from the Center for the Study of Social Policy, the goal for this study was to more fully understand how ACEs correlate with internal protective factors and to gather, from the perspective of the study participant, how they perceive the protective factors that have seen them through difficult times.

Buckner International was founded in 1879 by Reverend R. C. Buckner, who saw the need for a children's home while serving as a minister in Texas. Caring for those

most vulnerable and building strong families has been the focus of Buckner since its founding. Today, Buckner International serves families, children, and seniors through four core services; the Family Pathways Program, Family Hope Centers, Foster Care and Adoption Services, and services for senior adults (see Appendix A). In addition, Buckner has Shoes for Orphan Souls, mission services, and humanitarian aid programs for those in immediate crisis or need. This researcher selected Buckner's Family Pathways aimed at strengthening families through the five protective factors of educational support, concrete support, and social connections, including spiritual gatherings. The program offers housing while single parents return to school to complete a vocational, trade or higher education degree. The program added clinical services in 2017 to help address adverse experiences that may decrease the participant's success in the program (graduation). The clinical programming focuses on resiliency, parenting education, building a healthy attachment between parent and child, and identifying the emotional and developmental needs of the children in the parent's care. To further understand how to strengthen the clinical programming, the researcher, through qualitative questions and quantitative data collection, examined the relationships between the ACEs scores and the scores from the Resilience Scale, the Adult Hope Scale, the Spiritual Well-Being Scale, and the Adult Attachment Scale of the program participants.

Research Questions and Hypotheses

The ACEs scores were examined along three domains: childhood abuse, neglect and household dysfunction (Felitti et al., 1998). The internal protective factors were examined using the following inventories:

- Hope: The Adult Hope Scale (AHS; Snyder, Irving, & Anderson, 1991b)
- Resilience: The Resilience Scale (RS; Wagnild & Young, 1993)
- Spirituality: Spiritual Well-Being Scale (SWBS; Bufford, Paloutzian, & Ellison, 1991).
- Parental Attachment: Revised Adult Attachment Scale (RAAS; Collins, 1996)

In addition, the age of the parent, the number of children the parent had in his/her care, the race of the participant, and the length of time the parent had been in the program were also considered in relationship to each variable.

1. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Adult Hope Scale?

   Null Hypothesis 1a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Adult Hope Scale.

   Null Hypothesis 1b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1c: There will be no statistically significant relationship between the domain of child neglect scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale when age, race, length of time in the program, or number of children are considered.

2. Research question: Is there a relationship between Adverse Childhood Experiences Scores and the Scores on the Resilience Scale?

   Null Hypothesis 2a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Resilience Scale.

   Null Hypothesis 2b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2c: There will be no statistically significant relationship between the scores from the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale when age, race, length of time in the program, or number of children are considered.

3. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Spiritual Well-Being Scale?

   Null Hypothesis 3a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Spiritual Well-Being Scale.

   Null Hypothesis 3b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3c: There will be no statistically significant relationship between the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale when age, race, length of time in the program, or number of children are considered.

4. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Revised Adult Attachment Scale?

   Null Hypothesis 4a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Revised Adult Attachment Scale.

   Null Hypothesis 4b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4c: There will be no statistically significant relationship between the scores from domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4d: There will be no statistically significant relationship between the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale when age, race, length of time in the program, or number of children are considered.

5. Research Question: How does the participant view his/her resilience, hope, spirituality, and attachment patterns in relationship to or in spite of their adverse childhood experiences?

Theoretical Perspectives

Resiliency Theory

Resilience has been defined and redefined for decades. Walsh (1996) defined resilience as the "ability to withstand and rebound from crisis and adversity" (p. 261). Resilience was not only examined in terms of individual strength but relational strength, particularly within families (Walsh, 1996; Walsh, 2016). Resilience was viewed as a nature vs nurture phenomenon; some hardier families endured adversity well while less

hardy families did not. However, with a clearer understanding of the role of chronic stress and maltreatment on brain development, neurobiology, and mental health, research began to view resilience as impacted by nature and nurture (Broekman, 2011).

How are stress, chronic stress, and trauma different? In order to understand the power of resilience and a family's ability to withstand adversity, understanding the differences is significant. Richardson (2002) states that resilience research has moved from intervention and cure to the exploration of personal strengths and gifts. It is often considered the counterpart to stress, but the concept of stress can also be subjective. Chronic stress can be defined as demands placed on the body, mind, and spirit that threaten to exceed one's emotional and physical reserve. These may include areas of life such as family, marriage, parenting, work, health, housing and finances, and are often further impacted by societal, economic or racial oppression (Schetter & Dolbier, 2011). Trauma is defined as any event or accident that results in a physical, cognitive, social, economic, occupational, or emotional impairment (Honarpisheh, 2012). These definitions are changing as more research findings influence the field and the definitions seem to overlap (Schetter & Dolbier, 2011). However, the authors of the ACEs Study incorporated traumatic events (physical and sexual abuse), stress (parental separation or incarceration), and chronic stress (household member with substance abuse or mental health issue), understanding the intraconnected and interconnected of mental and physical well-being (Belis et al., 2017). Benard (1997) sought to change the way schools focused on "at-risk" children and families by taking a strength-based approach and noting that all

students had the capacity for transformation based upon the student's resilience. Research continued to demonstrate that some adults can repeatedly be exposed to acute stressors and not only manage them but also thrive in the face of adversity (Schetter & Dolbier, 2011).

This researcher viewed resilience in terms of transformation and thriving in the context of family systems, viewing the family as one unit (Calhoun & Tedeschi, 1998; Carver, 1998; Walsh, 2016). For those in high risk populations, such as those with an ACEs score of four or more, it is not enough to look at resilience as temporary coping. It must be viewed as a long-term protective factor (Browne, 2014; Walsh, 1996; Walsh, 2016). While family function or dysfunction can create generational patterns, no one family can be viewed as the "norm" as each family must be viewed within its own individual context (Walsh, 2016).

Resiliency theory, in connection with the protective factor model, has the potential to examine immediate and long-term adaptation (O'Leary, 1998: Walsh, 2016). The protective factor model recognizes that there is a correlation between protective factors and risk factors (O'Leary, 1998). The protective factor model of resilience stems from developmental research and systems theory. Walsh (2016) looks at belief systems, organizational processes, and communication processes to build resilience within individual, family, community, and socio-cultural levels. Protective factors aid in the recovery of stress, chronic stress, and trauma and foster positive outcomes in spite of ACEs (Browne, 2014; Ungar, 2004). The protective factors include emotional regulatory

skills, intrapersonal reflective skills, academic and job skills, ability to restore self-esteem, planning skills, life skills, and problem-solving skills (Ungar, 2004).

Attachment Theory

Bowlby (1957) recognized the attachment relationship between a caregiver and infant by examining the behavior, proximity, and safety that the infant felt with their caregiver. As attachment theory has developed, it is now understood that attachment systems are activated the moment an infant is born, through neural pathways, shaped and pruned in relationship to the care they receive (Schore, 2001). How the infant perceives danger or responds in fear that their basic needs for survival will not be met, shapes the way in which the infant responds to the world around them into their adulthood (Schore & Schore, 2008; Sroufe & Siegel, 2011). Four attachment styles are currently recognized in attachment theory: secure, ambivalent/preoccupied, avoidant/dismissive, and disorganized/unresolved (Main, 1996).

Children with attachment security explore the world with curiosity and return to their attachment figure for security, comfort, and protection (Bowlby, 1969). When allowed to explore and return, the child learns the cycle of attachment that provides the child with trust, self-efficacy, and self-worth that strengthen the child's resilience and see them through difficult challenges as they enter adulthood (Fahlberg, 1991; Purvis, Cross, Dansereau, & Parris, 2013). Attachment insecurity can occur when the relationship between caregiver and child is impacted by loss, separation, trauma, physical or mental illness, or maltreatment (Hesse & Main, 2000). In addition, parental attachment security

or insecurity is predictive of a child's attachment status, with a predicted representation between mother and child in 75% of the dyads studied (Fonagy, Steele, & Steele, 1991). Children with an insecurely attached parent, particularly one in which the attachment status is disorganized, report the lowest possible outcomes. Mothers, who have a disorganized attachment pattern, also report the lowest level of parental and spousal support, and the higher levels of partner violence (Finger, Hans, Bernstein, & Cox, 2009). For children who seek comfort in moments of stress or confusion, reassurance from abandonment threats, or attempts to express distress, parental insecurity further heightens the child's insecurity and perceived threats (Kindsvatter & Desmond, 2013). The cycle of attachment has an intergenerational impact, but change is always possible (Sroufe & Siegel, 2011).

Research has shown that attachment security can be obtained in spite of ACEs scores (Siegel & Hartzel, 2003; Sroufe & Siegel, 2011). This makes attachment theory an important component in healing trauma and building resiliency. Attachment theory and attachment status should be at the heart of the clinical intervention when working with those who have experienced trauma, maltreatment, neglect or household dysfunction (Sroufe & Siegel, 2011). If attachment status can impact cognitive development, social and emotional development, it seems imperative that attachment theory would and should be the foundation for those serving individuals who have experienced adversity (Schore & Schore, 2008; Sroufe & Siegel, 2011).

Definitions

Adverse Childhood Experiences (ACEs): ACEs includes all experiences that could have negatively impacted a child's life and life in adulthood. These include, but are not limited to sexual abuse, physical abuse, neglect, domestic violence, malnutrition, maltreatment, or exposure to substance abuse, mental illness, divorce or parental separation, or incarceration of a parent (Felitti et al., 1998). For this study, ACEs were also delineated into three categories; childhood abuse (physical, sexual, verbal), neglect (physical or emotional), and household dysfunction (parental separation and divorce, domestic violence, mental illness, substance use, and incarceration of a parent).

Child abuse: The Federal Child Abuse Prevention and Treatment Act (CAPTA) [42 U.S.C.A. § 5106g], as amended by the CAPTA Reauthorization Act of 2010) defines child abuse as "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation or an act of failure to act which represents an imminent risk of serious harm" (p. 6).

Child neglect: The Center for Disease Control (2017a) defines child neglect as a "failure to provide needs or to protect a child from harm or potential harm" (para. 3). This may include failure to provide for a child's basic physical, emotional, educational, or medical needs.

Household dysfunction: The definition of household dysfunction, as established by the ACEs Study, includes substance abuse of a household member, mental illness of

a household member, mother treated violently, and a household member who was imprisoned (Felitti et al., 1998).

Protective factors: Protective factors are the attributes or conditions that reduce the risks or help to reduce the stress for families, individuals, or communities, or for society at large (Browne, 2014).

Resilience: Resilience is the capacity to face stress without significant disruption in one's day to day functioning (Perry, 2002). The American Psychological Association (2017b) defines resilience as the adaption following adversity, trauma, and chronic stress that can be learned.

Hope: Hope is the perceived capability to reach one's desired goals and the motivation one has to reach those goals (Snyder, 2002).

Spirituality: Spirituality is defined according to the measurements in the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982) which includes one's perceived relationship with God, sense of purpose in life, and life satisfaction.

Attachment: Bowlby (1969) defined attachment as the "lasting psychological connectedness between human beings" (p. 194).

Delimitations

A delimitation of the study was that previous employment status, marital or relationship history, and religious history (identified religion or attendance at place of worship), which could impact the hope, resilience, attachment, and spirituality of the study participants were not factored into the relationship between the variables. The

researcher recognized that an individual's religious history, for example, might impact the participant's current spiritual beliefs, either positively or negatively. However, the study recognized that each individual's experiences are unique and the participant's hope, resilience, attachment, and/or spirituality may be impacted negatively or positively by their ACEs and therefore, did not seek to further explore the possible relationship variables in a historical context.

Assumptions

It was the assumption of this researcher that the study participants had a sincere desire to participate in the study. The study participants were informed that their participation in the study would in no way impact their standing in the Buckner Family Pathway's program. It was assumed that the study participants understood their role as study participants, which was different from their role as a program participant.

It was also assumed that the study participants were honest in their responses. While they may have wished to present themselves in a more positive light, the study participants were informed that that their responses were confidential and their responses would not be seen by or presented to program staff. There was a possibility that the study participants might intentionally self-report their protective factors of resilience, attachment, hope, and spirituality, as well as their ACEs, in a more positive manner. As study participants, their participation in the survey was completely voluntary and confidential.

Summary

As organizations focus on preservation of families with the goals of increasing sustainability through access to education and employment opportunities, organizations must also identify and address factors that could detain or hinder long-term transformation. From a clinical standpoint, internal protective factors can help or hinder family preservation and sustainability. Resilience and attachment, however, can be greatly impacted by the chronic stress and/or trauma of ACEs, leading to an increased intergenerational cycle of adversity. Organizations serving high-risk populations have a tremendous opportunity to wrap supportive and healing services around families to tackle both external and internal protective factors.

CHAPTER II

REVIEW OF LITERATURE

ACEs can include a multitude of challenges that plague families, from poverty to intimate partner violence to child abuse and neglect. Acts of omission, low social support, and neglect equally have potentially damaging impacts throughout the victim's life (Beutel et al., 2017). Children with low resilience and high exposure to childhood adversity are the most vulnerable to a lifetime of maladaptive coping (Beutel et al., 2017). Understanding the connectedness between adversity and the influence of protective factors in strengthening families is crucial for organizations providing social services and therapeutic support to adult parents and their children (Browne, 2014).

The Adverse Childhood Experiences Study

The ACES redefined traumatic events with their groundbreaking study that highlighted the impact of ACEs (Felitti et al., 1998). After the results emerged from this study, many researchers no longer viewed trauma as a "deeply disturbing event" or a physical injury. Trauma began to include chronic stress, household dysfunction, feeling unloved by a parent, and poverty (Honarpisheh, 2012). The ACES was conducted between 1995 and 1997 with patients at the Kaiser Permanente's San Diego Health Appraisal Clinic, explored ACEs from 18 years of age or younger, on adult health outcomes. The focus of the study was to target risk factors for adult behavior, such as drug use, domestic violence, and criminal activity and to assess adversity's impact on disease, mortality, quality of life and how those with adverse experiences access

healthcare. The questionnaire included ten questions which explored a range of adverse experiences, such as psychological, physical, or sexual abuse; violence against the mother; or living with a household member who was a substance abuser, mentally ill, suicidal, or ever imprisoned. Not only did the results of this study show a significant correlation between ACEs and disease, the number of those surveyed who had experienced adversity in childhood was definitive. As childhood adverse experiences rose, so did early mortality, disease, neurobiological delays, and delays in social and emotional development, in adulthood (Anda et al., 2006).

By 1997, over 17,330 adults had participated in ACES with surprising results (Felitti et al., 1998). First, 28% of the study participants reported having experienced physical abuse, and 21% reported having experienced sexual abuse. Two-thirds of participants reported at least one adverse childhood experience and 20% reported three or more ACEs. This was a surprising finding because the participants were college educated (39.2%), older (46.4% over the age of 60), white (74.8%) Americans with health insurance and could be considered a low-risk demographic. Overall, on a scale from 0-10, participants reported the following ACEs: none (36.1%), 1 experience (26%), 2 experiences (15.9%), and 3 experiences (9.5%). Among those surveyed, 12.5% experienced four or more ACEs, placing them at greater risk for heart disease, substance/alcohol abuse, liver disease, diabetes, chronic obstructive pulmonary disease (COPD), and early death, including suicide (Dube et al., 2001). The study also found a dose-response, or a graded relationship, between adversity and poor health outcomes. The

greater number of ACEs, the greater the individual's risk for physical and mental illnesses, and possible death (Dube et al., 2001).

Following the release of the ACE study, more studies emerged utilizing the ACEs Questionnaire (Anda et al., 2006; Cronholm et al., 2015; Flaherty et al., 2013). If the results of the ACES with a low-risk population yielded such a direct correlation between adverse experiences and health outcomes, how would those who in high-risk groups be impacted by childhood adversity? In one follow up study on 933 high-risk adolescents, 90% had experienced at least one adverse experience by the time they reached age 14 and as the number increased, health related issues also increased, demonstrating that health-related impacts of adversity begin at an early age (Flaherty et al., 2013). In addition, studies show an intergenerational impact of adverse experiences; what happens to one generation predicts the ACE of the second generation (Anda et al., 2009).

Over the last two decades, researchers have included the ACEs Questionnaire to assess risk for a variety of populations, shape social service policies and objectives, and build preventive programming (Anda et al., 2006; Browne, 2014; Metzler et al., 2017). Regardless of the increased understanding of the impact of adversity, childhood abuse and neglect remains a significant health issue. Child maltreatment in the United States is ranked as one of the worst records of all industrialized nation. On average, five children die each day as a result of child abuse and neglect in the United States (U.S. Department of Health and Human Services, 2017). One study examined adverse childhood experiences and parenting stress. In spite of socioeconomic status, those with higher

ACEs had increased parental distress (Steele et al., 2016). Yet, adverse childhood emotional, physical, and sexual abuses are preventable (Center for Disease Control, 2016).

The Adverse Childhood Experiences Questionnaire

The following review will present the 10 questions as stated in the ACEs Questionnaire with research on the development of the question and the impact of the specific adversity. The questions will also be categorized into one of the three domains: child abuse, child neglect, and household dysfunction.

Child Abuse

To develop and define the questions for child abuse, researchers utilized questions from the Conflicts Tactics Scale that defined the following two key questions in the ACE for psychological and physical abuse (Felitti et al., 1998). The question regarding sexual abuse was adapted from Wyatt (1985) study on the sexual abuse of women. According to Felitti et al. (1998), Wyatt developed four questions to define sexual contact in childhood that captured the information needed for evidenced-based outcomes. The U.S. Department of Health and Human Services (2017) released data on the maltreatment of children in America with staggering numbers. In one year, 3.4 million children were the subject of a Child Protective Services investigation, of which 683, 000 were determined to be the neglected or abused. It is estimated that 37.4% of children will experience a child abuse investigation by the time they are 18 years old (Kim, Wildeman, Jonson-

Reid, & Drake, 2017). How does the ACEs scale capture the reflective occurrence of child abuse and what has been learned about the impact?

Did a parent or other adult in the household…Often or very often push, grab, shove or slap you? Often or very often hit you so hard that you had marks or were injured (Felitti et al., 1998)? The Center for Disease Control (2017b) estimates that one in four children is a victim of physical, emotional, or sexual abuse. Research on outcomes for those who have experienced childhood abuse and neglect is grim (Jonson-Reid, Kohl, & Drake, 2012). As child maltreatment increases, negative outcomes, such as criminal history, truancy, mental illness, suicide attempts and substance use also increase (Jonson-Reid et al., 2012). In the original ACES, 26.4% of the respondents stated they had been the victim of child abuse (Felitti et al., 1998). A follow up study on suicide and ACE scores showed a strong correlation between suicide risks and adversity in childhood (Dube et al., 2001). Numerous studies have demonstrated a strong dose-response (ratio of adverse experiences to outcomes) between abuse and risk factors for disease. The greater the number of ACEs, the greater the risk for suicide, early death, substance and alcohol abuse, domestic violence, and mental illness (Dube et al., 2001).

Did a parent or other adult in the household…Often or very often swear at, insult, or put you down? Often or very often act in a way that made you afraid that you would be physical hurt (Felitti et al., 1998)? How to define abuse and neglect was discussed for several decades by U.S. policy makers and child advocates in the development of the Child Abuse Prevention, Adoption and Family Services Act of 1988

and amended in 2010 (English, 1998). Prior to the Child Abuse and Prevention Act of 1988, conversations among child placement professionals focused on how to define and deliver services to children who were endangered but whose parent had not caused any observable harm or risk of harm (English, 1998). Although a child may not suffer physical injury, the impact of psychological fear and verbal abuse burdens a child's emotional and psychological well-being, shaping childhood messages about safety and trust throughout the lifespan (English, 1998). Parental verbal aggression is associated with a variety of mood disorders and anxiety. Like physical abuse, verbal aggression can change the neurochemistry of the brain and heighten the child's fight, flight or freeze response, and reduce the brain's ability to cognitively process events in moments of stress (Tomoda et al., 2011).

Did an adult or person at least 5 years older ever…Touch or fondle you in a sexual way? Have you touch their body in a sexual way? Attempt oral, anal, or vaginal intercourse with you (Felitti et al., 1998)? The ACEs study began based upon Felitti's observation as Chief of Kaiser Permanente's Department of Preventive Medicine that the majority of the patients who were morbidly obese had been sexually abused as children (van der Kolk, 2014). From there, Felitti partnered with the Center for Disease Control to launch the ACES. The study revealed that 21% of the respondents stated they had been the victim of sexual abuse, and 10.2% stated they were victims of emotional abuse (Felitti et al., 1998). Sexual abuse has numerous neurobiological and emotional implications; victims may suffer from disassociation and post-traumatic stress disorder,

including a heightened startle response that places victims at greater risk for mental health disorders (Ben-Amitay, Kimchi, Wolmer, & Toren, 2016; Jovanovic et al., 2009). Seventy-five percent of those who reported being a victim of sexual abuse in childhood reported re-victimization in adulthood (Ports et al., 2016; Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007). Victims of childhood sexual abuse demonstrated a reduced ability to detect danger (risk appraisal) and increased self-blame and vulnerability (Walsh et al., 2007). Other studies indicate, similarly to the ACES, that children who have experienced sexual abuse, in addition to other types of maltreatment, show greater externalizing behaviors and a slower response to treatment for sexual behavioral problems (Tougas et al., 2016; Trickett, Noll, & Putnam, 2011).

Child Neglect

The impact of child neglect cannot be minimized. On the ACES-Q, questions were developed using the Childhood Trauma Questionnaire and formatted into yes/no responses on a Likert scale (Anda et al., 2009). In the 2017 Department of Health and Human Services statistics, more than half (63.4%) of the confirmed child maltreatment referrals to Child Protective Services were cases of neglect (Administration of Families and Children, 2017). Physical and sexual abuse often warrant immediate intervention and possible removal from the abusive situation into the home of a family member or foster parent. However, when a child reports feeling unloved, there is little systemic, government intervention available to provide protection and safety for that child.

Maltreatment due to neglect has a cumulative impact, impairing the child's well-being and development (English, 1998).

Did you often feel no one in your family loved you or thought you were important or special? Your family didn't look out for each other, feel close to each other, or support each other (Felitti et al., 1998)? Children who reported feeling their family stood by them and were loved demonstrated fewer health and behavioral outcomes than those who scored similarly on the ACE questionnaire (Sege et al., 2017). Those who did not feel their family stood by them, loved them, or felt they were special, had higher rates of depression (48.3%), suffered from poor health (27.2%), had higher rates of obesity (45%), and were more likely to smoke (32.2%) compared to those who endured three or more ACEs with the exception of this one. Feeling loved is foundational to overall well-being (Sege et al., 2017).

Did you often feel that you did not have enough to eat, had to wear dirty clothes, and had no one to protect you? Your parents were too drunk or high to take care of you or take you to the doctor if you needed it (Felitti et al., 1998)? There are shocking stories of physical abuse, sexual abuse, and domestic violence in the United States on a daily basis. Yet, physical neglect and household dysfunction, such as living with a household member who is using street drugs, abusing alcohol or has a criminal history, have the greatest dose-response to premature death (Anda et al., 2009). Yet, neglect is not necessarily a reflection of love, but a lack of consistent care in which a child's basic needs are met. Consistent early depravation of caregiving can lead to

dysregulation, cognitive delays, language delays, social and emotional functioning, and insecure attachment (Spratt et al., 2012).

Household Dysfunction

Questions for the domain of household dysfunction were based upon studies of alcohol use and physical violence in families (Anda et al., 2006), as well as studies on parental incarceration. Each of the following factors: divorce, mental illness, incarceration/imprisonment, and domestic violence have a tremendous impact on the well-being of children. Van der Kolk (2014) points out that chronic stress and developmental trauma change the epigenetic and neural development of children. Although a child may not be the direct victim of abuse or neglect, the stress from the following events creates a constant flow of stress hormones that have lasting repercussions (van der Kolk, 2014).

Were your parents separated or divorced (Felitti et al., 1998)? Parental separation can impact child outcomes significantly, particularly when there is parenting conflict, differences in parenting styles, and anger following the separation or divorce (Stallman & Ohan, 2016). In a longitudinal study, parental separation was associated with impulsivity in children. However, child anxiety, depression, and physical aggression were impacted if maternal symptoms were increased but otherwise showed no significant difference when scores were compared with children in non-separated families (Di Stefano & Cyr, 2014). The relationship between mother and father matters (Bowlby, 1957). But what if a parent is not present or a part of a child's life? In one study, in which

the results of cross sectional studies were compared on the data about father's absence, the outcomes remained consistent with the studies' original findings: absent fathers have a negative impact on a child's well-being, particularly from high school through adulthood (McLanahan, Tach, & Schneider, 2013).

Was your mother or step-mother ever grabbed, slapped, or had something thrown at her? Or sometimes kicked, bitten, hit with a fist, or hit with something hard? Ever repeatedly hit over at least a few minutes or threatened with a gun or knife (Felitti et al., 1998)? The question for intimate partner violence against the mother or step-mother was taken from the Conflicts Tactics Scale (Felitti et al., 1998). Systemically, what happens to one member of the family has an impact on everyone in the household (Browne, 2014). It is estimated that over seven million women each year are impacted by intimate partner violence and the majority of those women have children in the home (McDonald, Graham-Bermann, Maternick, Ascione, & Williams, 2016). One in 15 children in the United States witness domestic violence and the impact can be compromising to the resilience of children, particularly those exposed to animal cruelty in addition to violence against household members (McDonald et al., 2016).

Did you live with anyone who was a problem drinker or alcoholic (Felitti et al., 1998)? Questions for both alcohol use and street drugs were taken from the 1988 National Health Interview Survey (Felitti et al., 1998). It is difficult to separate problem drinking, alcoholism, illicit drug use, and mental illness as numerous studies demonstrate interrelatedness between the variables (Anda et al., 2006). When one author used logistic

modeling analysis to factor out other adverse experiences, suicide risk continued to have a graded relationship with alcoholism, depression and drug use (Dube et al., 2001). Substance and alcohol use and abuse increase as adversity increases. Researchers in the field of neuroscience found an early attempt by those suffering from post-traumatic stress disorder and chronic stress to neutralize, increase, or decrease the neurochemical impact of trauma (Anda et al., 2006). If this relationship exists for those who lived with a household member who was a problem drinker or alcoholic, who used street drugs or who suffered from depression, the intergenerational cycle becomes evident (Chapple, Hope, & Whiteford, 2005).

Did you live with anyone who used street drugs (Felitti et al., 1998)? In studies following the original ACES, individual adverse experiences were evaluated in relationship to health outcomes. For every ACE score, illicit drug use increased 2 to 4 times, showing a remarked dose-response relationship across multiple birth cohorts, ranging from 1900 to 1978 (Dube et al., 2003). According to the Child Welfare Gateway (2014), substance use among parents is a contributing factor in more than half of all cases of child abuse and/or neglect. With the increase in the legalization of marijuana, child protection workers are at a loss on how to manage growing marijuana use and the impact on children (Stott & Gustavson, 2016). Numerous studies have connected parental drug and alcohol use to child and adolescent drug use (Chapple et al., 2005). In one study, children with strong parental attachment to fathers were evaluated for licit (drugs taken legally) and illicit (illegal) drug use in adolescence. Even though the adolescents had

strong attachments to their fathers, those whose fathers used drugs were more likely to use drugs than their peers whose fathers were not using drugs (Drapela & Mosher, 2007). However, adolescent drug use has a distinct relationship with ACEs, likely due to the adolescent's feelings of chaos, instability and helplessness (Dube et al., 2003). These authors also demonstrate that the best way to fight drug use is preventative programs aimed at reducing ACEs (Dube et al., 2003).

Was a household member depressed or mentally ill? Or did a household member attempt suicide (Felitti et al., 1998)? Flaherty et al. (2013) stated that 57% of the youth had been exposed to neglect and household member depression. Children who live in fear of the parent who they rely upon for their basic needs face incredible disorganization in function and attachment (Hesse & Main, 2000). The duality of their needs vs their fear places children at tremendous risk for psychological harm. In a German study completed by Mattejat and Remschmidt (2008) on parental mental illness, maternal empathy, emotional responsiveness, and sensitivity were compromised with maternal depression. As the child ages, the child becomes fused with the parent's illness either attempting to parent the parent or due to increasing conflict, creating psychological and environmental stress for the child. While there is a genetic component to most mental illness, further impairment occurs because of the additional risks of child abuse and adverse environmental factors as a result of the parental mental illness (Mattejat & Remschmidt, 2008). As a result, children at genetic risk for mental illness face greater socioeconomic and health risks due to adverse experiences in childhood.

Did a household member go to prison (Felitti et al., 1998)? The Institute for Research on Poverty (2010) examined the impact of incarceration on families; in 2010, 2.7 million children had an incarcerated parent. Racially, 45% of minor children with an incarcerated parent are African American, 28% are White, and 21% are Latino (Institute for Research on Poverty, 2010). Studies on parents who have been involved in the criminal justice system or who are incarcerated have shown criminal activity as only one of the challenges children face (Phillips & Dettlaff, 2009). Domestic violence, abuse, and poverty are often additional challenges families face when the head of the household goes to prison (Phillips & Dettlaff, 2009). Post-incarcerated mothers showed greater than expected risks, including depression, drug and alcohol abuse, and poor health, than before incarceration (Turney & Wildeman, 2015). If parents do not fare better following incarceration, children face dire outcomes. Children face greater difficulty in school (cognitive delays), social stigmatization for having a parent in prison (social delays), increased aggression, anxiety and depression (mental health risks) and higher rates of poverty, including homelessness and hunger (Institute for Research on Poverty, 2010).

Protective Factors

As more researchers utilized data from the ACEs Study, research on resilience, particularly how to build resilience in those who have experienced adversity, has been plentiful. Child abuse and neglect impacts behavior, economics, physical well-being and mental health (Center for Disease Control and Prevention, 2017b). The impact to the human spirit, however, can deplete personal strengths. The Center for the Study of Social

Policy released The Strengthening Families Approach and Protective Factors Framework in 2003 (Browne, 2014). The purpose of the two-generational framework was to shift from a treatment and intervention perspective to a preventative approach to address the issues that lead to increase adversity and to strengthen parents and communities in a way that promotes the well-being of children (Browne, 2014). Five protective factors were developed to describe ways to decrease child abuse and neglect, strengthen families, and promote optimal child development. The five factors are (a) parental resilience, (b) social connections, (c) knowledge of parenting and child development, (d) concrete support in times of need, and (e) social and emotional competence of children.

From a systemic approach, each of the five protective factors is interconnected, just as the relationship between a parent and a child is interconnected, such that what happens to a parent, inadvertently impacts the children (Dube et al., 2009). As a result, ACEs carry lasting impacts that can hinder generations to come (Browne, 2014). In a study of childhood sexual abuse survivors, 10 to 53% of survivors were functioning at a normal level which was attributed partly to education, family and social support, social attachment, interpersonal and emotional competence (Domhardt et al., 2015). For those who have experienced violence, protective factors, such as resilience, play a critical role in recovery and future well-being (Sabina & Banyard, 2015).

Understanding what protective factors are, such as the important role they play in healthy family functioning and how organizations can build on, develop, and strengthen a family's protective factors is critical to family preservation and sustainability. It may not

be enough to for an agency to offer concrete support in times of need without providing social connections. It may not be enough for an agency to provide training and education for parents without also seeking to build emotional and social competency in children. Yet, these are often tangible and measurable objectives for organizations when assisting families, which leaves many family therapy and social service organizations to wonder how they can build resiliency in their clients, inspire hope, foster healthy attachments in relationships, and find faith in the midst of adversity (Browne, 2014). The following pages provide an overview of the internal protective factors that will be examined by within this study.

Resilience

Resilience research has increased exponentially in the last several decades (Walsh, 1996, Walsh, 2016). The question has been, and remains, why do some individuals endure hardships and thrive, while others do not? Capturing and understanding the human spirit is difficult as each person responds to trauma, loss, and adversity according to their history, their personality, their adaptation style, and relationships with others (Bonanno, 2004; Walsh, 1996). Research also suggests that there is no single formula or set of characteristics that define resilience, but include a number of factors that vary from individual to individual, such as tenacity, problem-solving skills, optimism, and the ability to bend and flex through crisis or loss (Beutel et al., 2017; Björkenstam et al., 2016; Boss, 2006). This is not only true for individuals but for family systems; what impacts one family member, impacts all (Walsh, 2016).

Resilience can buffer the impact of adverse experiences, decreasing mental and health issues that often plague those with increased childhood adversity. Boss (2006) discusses resilience in relationship to ambiguous loss. A child whose parent in incarcerated is facing a physically absent but psychologically present parent, which is an ambiguous loss. However, it is also important to note that those with increased childhood adversity show lower levels of resilience (Beutel et al., 2017). For example, children who have witnessed domestic violence, including the abuse or harm of a pet by a household member, demonstrated lower social competence and self-worth (Sabina & Banyard, 2015). For these children, mustering optimism, humor, and facing fears, characteristics that contribute to resilience, was difficult at best (Sabina & Banyard, 2015). However, the parent-child relationship matters. A parent who is more open to talking with their child about important topics, shows an interest in their child's activities and friends, and who manages their own stress regarding parenting reared children who are more resilient (Sege et al., 2017). It is important to remember that resilience is a process that is built over time (Boss, 2006).

Walsh (2016) developed key processes in working with family resilience. Those working with families develop an understanding of the family's belief system by seeing how the family makes meaning of adversity, how they are affirmed and encouraged, what gives them hope for the future, and understanding the spirituality of the family to fully transform and connect following adversity (Walsh, 2016). Key processes also include organizational processes (flexibility, connectedness, plus mobilizing social and economic

resources) and communication/problem solving, getting clarity, allowing space for emotional sharing, and working collaboratively to problem-solve (Walsh, 2016). Intervention programs aimed at providing support to parents and a trusted adult for children help to increase resilience and mitigate the impact of ACEs (Belis et al., 2017; Walsh, 2016).

Hope

Resilience may provide the internal structure that helps individuals rebound following adversity, but hope is the key ingredient to setting goals and meeting goals (Snyder, Irving, & Anderson, 1991b). Hope is defined as an expectancy in mediating goal-directed behavior which is impacted by optimism, self-efficacy, helplessness, and resourcefulness (Snyder et al., 1991b). Hope can seem elusive for those who have faced early life adversity. For those living in poverty and unemployment, their parents, grandparents and extended family most likely experienced the same (Metzler et al., 2017). Studies have also shown an intergenerational pattern of adversity. Those who were raised in homes with a household member who abused substances, are more likely to become substance abusers while those with a parent who has a mental illness are more likely to face a mental illness as well (Dube et al., 2001). Although those who have faced adversity may be resilient, they may lack hope in setting and obtaining goals. Increasing hope becomes critical in lifting up a generation and breaking the cycle of adverse childhood experiences. Hope captures one's determination and energy (Snyder et al., 1991a).

Snyder (2002) suggested that therapeutic hope has an important role in the process of healing (Nwoye, 2011). Placebos in experiments can induce perceived and, on occasion, medical recovery from disease, as the expectation of healing generates hope (Snyder, Irving, & Anderson, 1991b). In therapy, hope can be nurtured through support in articulating, clarifying, and identifying tasks to complete goals and helping the individual unpack goals to make them manageable and adaptive (Nwoye, 2011). Another factor in utilizing hope as a healing agent is through watching and imitating others who have undergone similar circumstances but have remained hopeful, and endured the storm (Nwoye, 2011).

Spirituality

In the Religious Landscape Study, conducted by the Pew Research Center (2015), 70.6% of Americans identified as Christian and 22.8% identified as unaffiliated to religion (agnostic, atheist, or non-religious). According to that study, religiosity and spirituality play a role, good or bad, in how most Americans see the world and themselves in the world. As a result, it is important for organizations to understand the impact that one's faith has on their previous experiences and healing (Stone, Cross, Purvis, & Young, 2003). Spirituality can be beautifully defined as a "subjective experience of the sacred" (Vaughan, 1991, p. 105). How a participant views their purpose and meaning in life, as well as what motivates the participant to do well and treat others well, can become a significant internal protective factor in healing from adversity in the therapeutic process (Vaughan, 1991). In a review study of various spiritual

questionnaires, spirituality was found as "one's striving for and experience of connection with oneself, connectedness with others and nature and connectedness with the transcendent" (Meezenbroek et al., 2012, p. 338).

However, for those who have experienced child abuse, neglect, and household dysfunction, making meaning out of complex trauma is difficult as shame, grief and loss, anger, and betrayal are often difficult emotions the victim navigates (Pressley & Spinazzola, 2015). Among those surveyed in one study on religiosity and PTSD, 39% of respondents stated that their beliefs about their faith never changed and 38% stated that their beliefs were not that important to them. Following a traumatic event, 22% stated their beliefs had changed and remained changed. Only 2% stated that their beliefs changed following a traumatic event but returned to where they were prior to the traumatic event (Falsetti, Resick, & Davis, 2003). In the Strengthening Families Framework, social support and connections are crucial for families facing adversity (Browne, 2014). The addition of a religious, supportive community can play an important role in increasing positive coping and strengthening people through difficult moments in their lives (Stone et al., 2003).

Attachment

The Center for the Study of Social Policy described the Social and Emotional Competence of Children as "as providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate and express emotions (Browne, 2014, p. 5). When working with families, it is imperative

to understand the systemic process of attachment and how secure parent-child relationships aid or hinder one's ability to regulate emotions, form healthy relationships and to ask for what one needs (Cassidy, Jones, & Shaver, 2013; Schore & Schore, 2008).

John Bowlby recognized the anxiety and stress children exhibited when separated from their mothers from which attachment theory developed (Ainsworth & Bowlby, 1991). In the attachment cycle, children explore, seek the care and safety from the parent to feel confident in their exploration, and return to the parent following exploration to the safety and security of their parent (Fahlberg, 1991). Bowlby noted that infants have a biological response to seek safety and security, and when faced with stress, seeks the proximity, nurturance, and attunement of the parent (Bowlby, 1969; Bretherton, 1992).

There are four attachment styles, or internal working models, in attachment theory; (a) secure attachment, (b) anxious preoccupied attachment, (c) dismissive avoidant attachment, and (d) fearful disorganized or unresolved attachment (Bowlby, 1969; Main, 1996). These early childhood attachments influence relationships developed later in adulthood with other adults, particularly romantic partners, children, and other family members (Sroufe, 2005). In other words, the attachment style acquired in childhood impacts how an individual will respond to the individual's needs and how the individual will go about getting these attachment needs met (Sroufe & Siegel, 2011).

Attachment patterns also play a critical role in family functioning and are considered an important link to behavioral and adaptive functioning in children (Murphy et al., 2014; Roskam, Meunier, & Stievanart, 2011). Children with an insecurely attached

parent, particularly one in which the attachment status is disorganized report the lowest possible educational, socioeconomic, and physical and mental health outcomes having endured the greatest number of ACEs. Mothers who have a disorganized attachment pattern, also report the lowest level of parental and spousal support, and higher levels of partner violence (Finger et al., 2009; Murphy et al., 2014). For children who seek comfort in moments of stress or confusion, reassurance from abandonment threats, or attempt to express distress, parental insecurity then further heightens the child's insecurity and perceived threats (Kindsvatter & Desmond, 2013). This is particularly true for children who seek the safety of the parent who is also the one causing the child's distress or fear through frightening or threatening behavior (Hesse & Main, 2000).

While many studies examine maternal attachment and infancy, Roskam, Meunier, and Stievenart (2011) conducted a longitudinal study examining the attachment status of children, mothers and fathers, in relationship to externalizing behaviors in the children, in order to explore the link and importance of attachment status on a child's behavior. Parental attachment played a significant and predictive role in the externalizing behaviors of children. Another important outcome of the study revealed the importance of paternal attachment security on childhood externalizing behaviors. Fathers with secure attachment status had children with fewer behavioral issues. In contrast, mother's childrearing behaviors played as significant a role in externalizing childhood behaviors as attachment status (Roskam et al., 2011). Creating an environment that enables a child to regulate and express emotions appropriately can be directly correlated with parents learning more

about attachment security and gaining the tools to build safe and secure relationships with their children (Sroufe & Siegel, 2011).

In addition, with the advancements in the field of trauma and neurobiology, ACEs and the attachment relationship have been examined in new ways (Cassidy et al., 2013; Schore, 2014). Research has shown the impact of trauma on the brain, but the brain also allows for healing and adaptation (Schore & Schore, 2008; van der Kolk, 2014). In the parent-child relationship, the parent is responsible for guiding the child to a secure attachment by creating opportunities for the child to explore their world safely and to return to the trustworthy and loving parent (Fahlberg, 1991). Research in the area of neuroscience has provided professionals with significant insights into attachment development and emotional reactivity connected to fear and trauma (van der Kolk, 2014). The nurture and care received in infancy have a significant impact on the wiring of the brain and thus ability to learn to attach. Messages of safety, reflections of worth, and the attunement of the caregiver or parent complete the neural development needed for babies to develop a secure attachment (Purvis et al., 2013; Schore, 2001)

Early research shows infants left unattended, without human nurturance, or social interaction, do not thrive (Fishbane, 2007). Humans are literally wired to connect. Chronic misattunement in infancy, along with ACEs, can have a lasting impact on attachment, responses to stress, cognitive functioning, and emotional development. However, the brain's limbic system, particularly the amygdala, can also recover in a calming, nurturing environment (Fishbane, 2007). Parents must be given the knowledge

and the tools to provide with their children with what they may not have received themselves in order to heal the intergenerational impact of ACEs.

In repeated exposure to adversity in childhood, neurobiological responses become pathogenic rather than protective (Flaherty et al., 2013). ACEs are interrelated, such that as adversity increases, the mind, body and spirit can be weakened (Dube et al., 2009; van der Kolk, 2014). As a result, organizations must consider interventions to increase protective factors to reduce the dose-response for adversity. Early detection of adverse experiences and increased service provision can help prevent the intergenerational impact, but the question remains that the degree, quality, and timeliness of intervention needs further clarification (Jonson-Reid, Kohl, & Drake, 2012).

Summary

The information presented in this chapter is crucial to the understanding of adversity and the importance of capturing an individual's hope, resilience, spirituality, and attachment in relationship to the number of ACEs they have endured. For example, as ACE scores increase, sexual promiscuity, early intercourse, and sexual dissatisfaction also increase, perhaps from disrupted or insecure early attachments in childhood (Anda et al., 2006). However, the grimmest outcome is suicide. For those who have experienced adversity, it cannot be underestimated or minimized that the risk of suicide increases with as ACE scores increase (Dube et al., 2001). With each increase in an individual's ACE score, the risk of suicide increased by 60% in a sample of 17,330 individuals (Dube et al., 2001). Capturing feelings of hopelessness, providing therapeutic interventions to treat

neurobiological impacts of trauma, diagnosing post-traumatic stress or complex developmental trauma, and healing for early childhood adversity are crucial for building hope and reducing risks (Mertzel et al., 2017).

Research has also shown that the higher the ACE score, the higher the risk of poverty (Dube et al., 2009; Mertzel et al., 2017). The external protective factors of concrete support in times of need, education, and training for parents, and social support help reduce the long-term impact of ACEs and decrease the risks of adversity for the following generations. With an increase in education and support, lives can be transformed. With education, comes literacy and problem solving skills. With education comes employment that leads to skill-building and social support. With employment, comes the income that leads to health, a stronger sense of self and self-sufficiency in one's ability to care for themselves and others (Mertzel et al., 2017). Again, this creates an intergenerational process for children who fare better when parents exhibit good or excellent well-being and health (Sege et al., 2017).

This requires trauma-informed, long term, sustainable services and program prepared to strengthen families (Browne, 2014: Schore, 2014). While Bowlby contributed to the foundation of attachment and the developing theory of attachment, neuroscience has contributed to the how attachment develops and how relationships are healed (Sroufe & Siegel, 2011). Affect regulation and the emotional development of an individual begin immediately in the right brain, if not before an infant's arrival into the world (Schore, 2014). But what happens when trust, safety, security and predictability were replaced

with adverse experiences in childhood? Schore (2014) stated that therapy is a right-brain to right-brain interaction. Serving families and children by strengthening protective factors needs to be both cognitive and emotional; right brain and left brain (Browne, 2014; Schore, 2014). The delivery of concrete services that can enhance economic growth and sustainability, educate parents on their children's needs, and help reduce additional risks to vulnerable families are cognitive-behavioral activities (left-brain) that can have a right-brain, emotional impact when stress, fear, and instability are reduced. However, spirituality, attachment, resilience, and hope are internal protective factors that may have been compromised as a result of relational deficits or harm. In order to build internal protective factors, social service organizations should recognize the emotional and social component of healing (right-brain). Therapy is a "relationship of care" (Schore, 2014, p. 395). Adult coping following adversity is adaptive and serves a purpose, even when the outcome is negative (Felitti et al., 1998; van der Kolk, 2014). For lasting familial transformation, organizations need to have a multilayered, multidiscipline, long-term approach to ensure program participants are exchanging unhealthy family patterns and functioning for healthy functioning and not new maladaptive behaviors. In addition, for those served, adverse childhood experiences that transpired within relationships must be healed within relationship.

CHAPTER III

METHODOLOGY

This mixed method, online study was conducted examining the relationship between adverse childhood experiences and the internal protective factors of hope, resilience, spirituality, and attachment, from the perspectives of single parents. The quantitative measurements included demographic questions, questions from the ACES Questionnaire (Felitti et al., 1998), the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982), the Resiliency Scale (Wagnild & Young, 1993), the Adult Hope Scale (Snyder, 2002), and the Revised Adult Attachment Scale (Collins, 1996). In addition, the researcher asked five descriptive, open-ended questions to provide an opportunity for participants to expand, voluntarily, on the quantitative data (Creswell, 2009; Dillman, Smyth, & Christian, 2014). This chapter explains the methodology that was utilized to conduct the study by providing a description of the participants, a description of the instruments that were used in the data collection, and the procedures and details of the data collection and analysis.

A mixed methods online approach was utilized to provide the opportunity for participants to engage in both a closed and open-ended format. To examine one's adverse experiences in relationship to their internal protective factors, this researcher also felt it was imperative for the individual to have the opportunity to provide meaning or insight into their experiences. However, the quantitative data was the primary focus of the study

in order to minimize bias and allow for generalizability for clinical application (Creswell, 2009).

Site and Participant Selection

Buckner Children and Family Services, Inc. was selected because of the multi-dimensional layers of support the organization provides to the program participants. It should also be noted that although Buckner Children and Family Services, Inc. is a Christian organization, Christianity is not a prerequisite or requirement for program entry or program services. Buckner adheres to three cultural values: Christ-like, servant-spirit, and passion-driven for those serving program participants (retrieved from www.buckner.org). Respect for where each of the program participants may be in their own spiritual journey was a priority in this study.

Description of the Population

This voluntary, online study included program participants from Buckner Children and Family Services, Inc. Family Pathways Program. The Family Pathways Program is one of three core service offerings under Buckner Children and Family Services, Inc. The program participants are male and female, between the ages of 18 to 45, are enrolled in a higher education program, and are single parents. The Pathways participants live on Buckner's campus or in housing provided by Buckner in the following locations: Dallas, Longview, Lufkin, Conroe, Houston, Midland, Lubbock, and Amarillo. While in the program, the parent has access to financial classes, individual and family therapy, parenting classes, and family events, such as Family Camp during

Spring Break, meeting the five protective factors from the Strengthening Families' Protective Factors Framework (Browne, 2014). The Family Pathways participants are earning a higher degree and have access to a computer and internet service. Access to services provides an opportunity for the program participants to increase the internal protective factors of resilience, hope, spirituality, and attachment, allowing the variables to be evaluated with some degree of equity.

Ethnic diversity within the Family Pathways program can vary year to year, depending on the applicants and the number of participants entering and exiting the program. However, at the time of the study, the overall demographics within the program, according to the Buckner's Director of Program Design, were 37.7% African American, 34.4% White, 18.6% Hispanic or Latino, and 7.1% identified as another ethnic background or multi-racial, and 2.1% were unknown or did not specify their ethnicity.

A post-hoc statistical power analysis was performed for sample size estimation. With a power = 0.80 and the alpha =.05, a minimum of 34 study participants were needed for moderate to high results and 44 participants were needed for a 2-tailed correlation. Sixty-five study participants were needed for linear regression or ANOVA. A final sample of 51 study participants provided an adequate sample for the objectives of this study to be tested using correlational analysis but not linear regression or ANOVA.

Procedures

Protection of Human Participants

Prior to development of this research study, permission was requested from Senior Leadership at Buckner Children and Family Services, Inc. in order to ensure collaboration, support of the study, and to discuss expectations for staff and participants (see Appendix B). Once permission was obtained from Buckner Leadership, approval was requested and granted from the Texas Woman's University Institutional Review Board (IRB; see Appendix C) and the Graduate School (see Appendix D).

To protect the identity of the participants, no identifying information, such as names, addresses, dates of birth, or family members' names were requested, while the participant completed the study survey. The participants were informed of their rights, which include their voluntary participation in the study. They were informed that they were free to withdraw from the study at any time. They were also informed that their identities were protected throughout the study and that identifying data would not be collected.

All survey and data responses, transcriptions of qualitative data, and the SPSS data analysis software will be maintained for a period of five years following the completion and publication of the study. After five years, the survey responses will be destroyed. This researcher may use the results of this study in professional, public or research presentations or publications. Participant anonymity and confidentiality will be protected in alignment with Health Insurance Portability and Accountability Act of 1996 (HIPAA)

ethical guidelines as the researcher is also a licensed professional counselor (HHS.gov., 2018).

Identification of Risks

Risks to the participants included the recollection of traumatic or difficult memories that could require further clinical follow-up. Each of the participants was provided with the names of therapeutic resources. Each ethical consideration was incorporated into the research design in order to ensure that each participant felt safe, unthreatened, and remained an active volunteer in the study. If participants experienced fatigue or emotional discomfort, they were encouraged to take breaks and, then, return when possible to complete the online survey.

Sampling

Identification of the participant pool. Email addresses were obtained through the Extended Reach Database utilized by Buckner Children and Family Services, Inc. that tracks client information and case activity. Of the 169 program participants in the Buckner Family Pathways Extended Reach database, those without email addresses, with incorrect email addresses, or those who asked to be removed from the email list, were not included in the final sample of 149 possible participants. The remaining program participants were recruited electronically by email invitation. An email (see Appendix E) with an attached flyer (see Appendix F) concerning this study was sent on six occasions over a period of three months, inviting them to participate in the study. While participants who entering the Pathways program were added to the study participant list, those exiting

the program were not removed as it was determined that they would have current information to share should they choose to do so.

Recruitment. This researcher, who also serves as the Director of Counseling for Buckner Children and Family Services, Inc., informed the program staff about the study and asked that no influence or pressure from the program staff be applied to hinder or boost participation. The researcher discussed with the program staff the importance of allowing participants to freely agree to participate, without influence, in the study. However, the program staff was provided a copy of the Research Study Flyer to share with incoming (new) participants. The staff and the flyer directed the new participants to contact the researcher with any questions.

Sample. The sample consisted of 51 participants. Age, number of children, length of time in the program, ethnicity, and degrees completed and degree the participant was currently seeking were requested in the demographic survey. Gender was not requested as less than 2% of the program participants are single fathers and the probability of being identified based on gender was high. All participants in the study were English speaking. The sample will be described in Chapter 4.

Research Questions and Hypotheses

There were five scales/questionnaires, in addition to five qualitative questions and the demographic questions, to answer the following research questions:

1. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Adult Hope Scale?

Null Hypothesis 1a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Adult Hope Scale.

Null Hypothesis 1b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1c: There will be no statistically significant relationship between the domain of child neglect scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale.

Null Hypothesis 1e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale when age, race, length of time in the program, or number of children are considered.

2. Research question: Is there a relationship between Adverse Childhood Experiences Scores and the Scores on the Resilience Scale?

Null Hypothesis 2a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Resilience Scale.

Null Hypothesis 2b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2c: There will be no statistically significant relationship between the scores from the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale.

Null Hypothesis 2e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale when age, race, length of time in the program, or number of children are considered.

3. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Spiritual Well-Being Scale?

Null Hypothesis 3a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3c: There will be no statistically significant relationship between the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale.

Null Hypothesis 3e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale when age, race, length of time in the program, or number of children are considered.

4. Research Question: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Revised Adult Attachment Scale?

Null Hypothesis 4a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4c: There will be no statistically significant relationship between the scores from domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4d: There will be no statistically significant relationship between the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale.

Null Hypothesis 4e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale when age, race, length of time in the program, or number of children are considered.

5. Research Question: How does the participant view their resilience, hope, spirituality, and attachment patterns in relationship to or in spite of their adverse childhood experiences?

Quantitative Data Collection and Analysis

The survey used for quantitative data collection included demographic questions, questions from the ACEs Questionnaire (Felitti et al., 1998), the Adult Hope Scale (Snyder, 2002), the Resiliency Scale (Wagnild & Young, 1993), the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982), and the Revised Adult Attachment Scale (Collins, 1996).

Instruments

Demographic questionnaire. The demographic questionnaire (see Appendix H) gathered data about each of the participants in the study that were be relevant to the study questions. All Family Pathways participants were eligible to participate in the study. Demographic questions included:

1. Age: 19 to 45 years or older
2. Race/Ethnicity: African American, White, Hispanic/Latino, Asian/Pacific Islander, Native American or Middle Eastern
3. Current or completed educational level: High school diploma or equivalent, trade/technical or vocational training, associate's degree, bachelor's degree, Master's degree or professional degree
4. Employment status: Employed for wages, unemployed but looking for work, unemployed and not looking for work, unable to work, military, or self-employed, and
5. Number of children living in the home with the participant.

Following the demographic questions, the participant was provided with a statement notifying them that the next 10 questions would be from the Adverse Childhood Experiences Questionnaire (ACES-Q; see Appendix I), the Resilience Scale (RS; see Appendix J), the Adult Hope Scale (AHS; see Appendix K), the Revised Adult Attachment Scale (RAAS; see Appendix L), and the Spiritual Well-Being Scale (SWBS; see Appendix M).

Adverse Childhood Experiences Questionnaire. The ACES-Q (see Appendix I) was created by the co-investigators, Robert F. Anda and Vincent J. Felitti, of the ACE study conducted through Kaiser Permanente and published in 1998. The survey consists of 10 questions pertaining to abuse, neglect, and household dysfunction. Under the category of abuse, there are three questions in the ACEs survey that asks questions pertaining to emotional abuse, physical abuse, and sexual abuse. Under the category of neglect, two questions ask about emotional neglect and physical neglect. Under the category of household dysfunction, five questions ask questions relating to mother treated violently, household substance abuse, parental separation, or divorce, and incarcerated household member. For each "yes" that is answered by the participant a score of one is awarded, with a possible score of 1 to10.

Validity and reliability. The ACES-Q has the advantage of covering a wide range of childhood maltreatment experiences, more than any other currently available questionnaire. However, there is limited information regarding its psychometric properties (Zanotti et al., 2017). Internal consistency for the original ACE study indicated

moderate agreement for questions with dichotomous (Cohen's Kappa = .46 to .86) and ordinal responses (emotional and physical abuse, domestic violence; Cohen's Kappa=.56 to .72). In one study among college athletes, the test-retest coefficient was $r = .65$, $p < .001$ in household dysfunction, a higher stability coefficient than the test-retest reliability of the abuse and neglect domains (Zanotti et al., 2017).

Dube and colleagues (2001) examined the test-retest internal consistency for the ACE construct from a sample of the first Wave of the original larger epidemiological study conducted by Felitti et al. (2008) where the mean age for the sample was 64. Wave I of the ACE study did not include the neglect category. They found a weighted-kappa coefficient of .64 for the total ACE score. A kappa value of $\geq .75$ signifies excellent agreement, .40 to .75 signifies good agreement, and <.40 signifies poor agreement (Fleiss, 1981). For subcategories, their findings demonstrated Kappa coefficients of .66 for emotional abuse, .55 for physical abuse, and .75 for violence against mother. For household dysfunction dichotomous variables, their findings indicated Kappa coefficients of .86 for divorce/separation, .75 for substance abuse, .46 for criminality, and .51 for mental illness. As stated above, neglect was not included in Dube et al.'s (2001) study. However, research of a community sample of adults found emotional neglect and physical neglect questions had good internal consistency with Cronbach's alpha level of .85 and .68 respectively (Bernstein et al., 2003). In addition, the neglect questions of the CTQ were found to have good criterion-related validity in a group of adolescent psychiatric inpatients. Sexual abuse questions were adapted from the

CEVQ (Walsh et al., 2007), which allows for responding and scoring on a Likert-scale. Walsh et al. (2007) found the test-retest intra-class correlations for sexual abuse was .92 in a group of adolescents. A comparison of youth self-report sexual abuse classification and clinicians' judgment found Kappa coefficients of .70.

In regards to validity, the questions to determine the domains of abuse, neglect, and household dysfunction were taken from previous inventories in which validity had been determined (Murphy et al., 2014). However, a critique of the ACES-Q is that the questions are reflective and the validity of the individual's experiences is not questioned. Hardt and Rutter (2004) assessed the validity of retrospective reports of ACEs and caution using any measure that relies on retrospective reporting. The authors stated that positive reports are usually true reports, but adverse experiences are not necessarily always reported due to the nature of the information being requested and can lead to many false negative reports. This is not a problem with the measure itself, but an issue of how individuals tend to inaccurately report retrospective experiences. Retrospective reporting, though, is the quickest and easiest way to obtain data about ACEs.

The Adult Hope Scale. The Adult Hope Scale (see Appendix K) is a 12-item self-report inventory built on Snyder's hope theory which focuses on one's optimism, self-efficacy, and self-esteem (Snyder et al., 1993). This scale was selected for this study as it captures the internal protective factor of hope in light of adversity. The 12-question scale consists of two subscales:

- Agency: Having a sense of control over one's life and goal directed energy to achieve goals and tasks
- Pathway: Making a plan of action to accomplish goals and tasks (Snyder et al., 1991).

Agency and Pathway are connected and hope comes from both. However, an individual may, at different times in their life, have more Agency and less Pathway or vice versa (Snyder et al., 1996a).

***Validity and reliability*.** Upon development of the Adult Hope Scale, several studies examined the validity and the reliability of the scale, which has remained consistent in studies researching its validity and reliability (Babyak, Snyder, & Yoshinobu, 1993). Internal consistency for the Adult Hope Scale overall ranged from .23 to .64 for Cronbach's alpha. For agency subscale, Cronbach's alpha ranged from .71 to .76. For Pathways subscale, the Cronbach's alpha ranged from .36. to .80. Test-retest reliability across multiple samples of college students showed coefficients of .85, .73 (3 week), .76 (8 week) and .82 (10 week). Factor analysis was used to explore the two subscales; agency and pathways, which correlated positively. Convergent validity was measured using other inventories that examined Optimism as it closely identified with agency and Generalized Expectancy for Success Scale, which identified closely with pathways. Discriminant validity was measured using scales for private and public self-consciousness. In both, there was a predictable relationship between the constructs of the Adult Hope Scale (Snyder et al., 1991b).

The Resilience Scale. In one methodological review of resilience measurements, nineteen measures were evaluated; none met high standards for validity. The challenge, to some degree, is the definition of resilience (Windle, Bennett, & Noyes 2011). Resilience measurements are used in medicine, post-war services, grief and loss, with the elderly, and adverse experiences. As a result, measurements used for different populations resulted in differences in the data the measurements were capturing. The Resilience Scale (Wagnild & Young, 1993) best met the purpose intended for this study (see Appendix J). The scale is a self-report of the individual's equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness as defined below (Wagnild, 2011):

- Purpose: Having a sense of one's meaning in life which propels us forward in spite of setbacks
- Equanimity: Having a balance and harmony in life with some degree of flexibility to withstand challenges and disappointments as they arise
- Perseverance: Having the will to keep going following discouragement, rejection, failure or difficulties
- Self-reliance: Having refined problem-solving skills based upon one's strengths and capabilities that one relies on when facing challenges
- Existential aloneness: Having a sense of authenticity in who one is and is able to see themselves clearly in relationship with others (Wagnild, 2011).

The scale has been used with men, women, adolescents, and older adults and across cultures (Pritzker & Minter, 2014; Windle et al., 2011).

The scale consists questions answered with a Likert scale with responses ranging from 1 to 7 (strongly agree to strongly disagree); the scale measures individual self-esteem, social support, and self-reported health (Wagnild, 2011). Each answer response is tallied with a final score ranging from 25 to 175. The higher the score, the greater the participant's reported resilience (Wagnild, 2011; Wagnild & Young, 1993).

Validity and reliability. The 25 item Resilience Scale has been used in multiple research studies and was found to have strong internal consistency reliability (r=0.91) and good concurrent validity (Wagnild, 2011). Scores range from 24 to 223 with a mean score of 148.3. A low resilience score is 111.55 and a high resilience score is 165.89. Concurrent validity was evaluated using measures for depression (r=0.41, $p \leq$0.0001), morale (r=0.32, $p \leq$0.001), health (r= -0.26, $p \leq$ 0.001), and life satisfaction (r= 0.37, $p \leq$ 0.001).

The Spiritual Well-Being Scale. The Spiritual Well-Being Scale (see Appendix M), developed in 1983 is a 20-item questionnaire using a 7 point Likert scale. The SWBS was chosen by this researcher as the means to measure the current state of participant spirituality. Ten of the questions examine religious well-being and ten questions examine existential well-being. The Existential subscale looks at one's well-being in relationship to their quality of life, their sense of purpose and their overall satisfaction in life. The Religiosity subscale looks at their well-being in relationship to God.

Researchers have shown both declines in religiosity and increases in religiosity following trauma (Falsetti et al., 2003; Koenig, 2012). However, how the individual perceives themselves following adversity or trauma is significant in the clinical setting and this study sought to capture both religious and existential spirituality.

***Validity and reliability*.** The psychometric qualities of the SWBS are described below. One study noted that Cronbach's alpha = .89 (Monod et al., 2011). In a test-retest completed by the developer of the scale, coefficients were .93 for the overall SWB scale, .96 for religious wellbeing, and .86 for existential wellbeing, showing high reliability (Bufford, Paloutzian, & Ellison, 1991). Convergent validity was demonstrated between the association between the Existential subscale and sense of purpose in life and life satisfaction (Ellison, 1983). The Religious subscale was associated with a sense of purpose in life related to one's religious beliefs based upon a more deeply held religious paradigm. (Bufford et al., 1991; Koenig, 2012; Meezenbroak et al., 2012).

The Revised Adult Attachment Scale. In this study, strengthening family relationships through the protective factor of social and emotional competency of children and parenting knowledge was best captured by the RAAS. This study did not seek to classify individual's attachment patterns but to examine how the individual viewed three elements of adult attachment; depend, close and anxiety (Collins, 1996). The RAAS, an 18-item self-report, Likert scale consists of three subscales:

- Anxiety subscales are based upon the extent to which the respondent worries about being unloved or abandoned

- Closeness subscale is based upon the respondent's level of comfortableness with intimacy
- Depend subscale is based upon whether the respondent feels they can trust that others are there when needed.

Results from the RAAS can predict relationship quality (Collins, 1996; Graham & Unterschute, 2015).

***Validity and reliability*.** In a meta-analysis containing more than 313,000 individuals from more than 500 studies, five adult attachment measures were reviewed (Graham & Unterschute, 2015). Overall, the RAAS produced reliable results in college students, non-white populations, and in younger adults, compared to older adults; all affirming for this study. The Revised Adult Attachment Scale correlates with other attachment measures and is valid in its use to measure attachment (Graham & Unterschute, 2015). The Close and Depend subscales are highly correlated (r = .53). The Anxiety subscale was negatively correlated with the Close and Depend subscales at .34 and .46 (Collins, 1996). The reliability of the Anxiety subscale was strong, while the Close and Depend subscales was acceptable (Graham & Unterschute, 2015).

Qualitative Data Collection and Coding

Open-Ended Exploratory Question

Phenomenological research is aimed at understanding and analyzing one's experiences (Quay, 2016). Understanding the adverse experiences of the study participants, as well as their perception of their own resilience, attachment, hope and

spirituality could provide meaningful insight for those serving similar populations. If the study participant believed or recalled experiences of abuse, neglect, or household dysfunction, the scores from the RAAS, AHS, SWBS, and RS would likely reflect their viewpoint, which was useful data for this study. Through inductive and logical analysis, data could be tested to note any patterns or exceptions to the variances of the scores (Patton, 1999).

Research Question: How does the participant view his/her resilience, hope, spirituality, and attachment patterns in relationship to or in spite of their ACEs? The sample participants were asked five questions that explored the five quantitative variables: ACEs, hope, spirituality, resilience, and attachment (Creswell, 2009). The open-ended qualitative questions are as follows:

- Following the ACES: Is there anything else about your childhood that you would like to share?
- Following the questions on hope: Is there anything you would like to share that you believe may have helped or hindered your feeling of hope?
- Following the questions on resilience: Is there anything else you would like to share that you believe may have helped or hindered your resilience?
- Following the question on spirituality: Is there anything you would like to share that you believe helped or hindered your spiritual beliefs or actions?

- Following the questions on attachment: Is there anything else you would like to share about your relationships with others, including children, parents, or romantic partners?

Coding Procedures

The researcher and a second coder, the researcher's major professor, analyzed the open-ended questions searching for emerging themes among the responses. The qualitative questions followed the quantitative questions on *PsychData*. As a result, the responses were easily transferred to excel and did not have to be transcribed. After organizing the data and coding the data by hand, interrelated themes and descriptions were identified (Creswell, 2009). The contents were categorized within the emerging themes in order to maintain an audit trail and to ensure the researchers did not interpret the content subjectively. Once 80% agreement had been reached with Cohen's Kappa, steps were repeated until agreement was met (Patton, 1999). The identified themes were assigned to the original research questions addressing the areas of resilience, hope, spirituality, and attachment in light of their ACEs.

Trustworthiness, Rigor, and Credibility

Seidman (2006) pointed out the challenges in establishing validity in exploratory interviewing by questioning whether the researcher or interviewer is aware of when the participant may not be telling the truth. This study did not set out to look at the truthfulness of the person's experiences but their perspectives on their experiences in relationship to their strengths. In addition, the qualitative data were collected online and

in a confidential format to reduce the possibility for participants to minimize their adverse experiences or paint their history in a more positive light.

Credibility, transferability, and confirmability are used to establish trustworthiness in qualitative research (Marshall & Rossman, 2011). The researcher and the advising professor examined the data and confirm the noted themes to help to establish the trustworthiness of the study. By utilizing two coders and two methods of data collection; quantitative and qualitative, a more complex picture of the program participant's perceptions of resilience, hope, spirituality, and attachment were obtained. It also helped to limit researcher subjectivity from the data analysis.

Finally, transferability lies at the heart of this research study. The goal of this study was to examine how organizations focused on serving vulnerable populations can strengthen services to include internal protective factors in addition to external protective factors. It was the hope that this study will help not only support the services of the organization under study but other organizations who desire to empower, equip, and support families.

Data Collection

- From April 30, 2018 to July 18, 2018, six emails were sent to new and existing program participants to notify them of the study, to provide the link to access the study, to provide the researcher's contact information to ask questions about the study, and with the Research Study Flyer attached (see Appendix F).

- The participants were provided with an overall objective of the study and a link to PsychData to learn more about the study and to participate, if they chose.
- Each inventory, along with the demographic and qualitative questions, was uploaded into *PsychData.*
- When accessing the survey through *PsychData*, a consent form (see Appendix G) was placed on the first page of the *PsychData* online study so that the participant would be fully informed about the study and the criteria for participation. The consent form notified the participant of the purpose of the study, a summary of the participant's rights in completing the study, the name of the researcher's adviser at Texas Woman's University, and any risks to the participant, including fatigue, physical and emotional discomfort, and length of time anticipated to complete the survey (see Appendix G).
- A list of therapeutic resources was provided to each participant in the Consent to Participate in the Research and at the end of the survey (see Appendix G).
- At the end of the survey, the study participants had the option to click on the link at the end of the survey, taking them to a separate, follow-up survey where the participant could enter their name and address, and request a copy of the study summary upon its completion. By entering their name and address, they were provided with a $25.00 Walmart Gift Card for their participation. Gift cards were mailed to the participants within 30 days of completing the survey.

The Self of the Researcher

The researcher is an integral part of qualitative research (Creswell, 2009). Bracketing is a process that provides the researcher with the opportunity to explore and acknowledge preconceived assumptions and biases that may influence research design and analyses (Tufford & Newman, 2010). While participants may have known the researcher as the Director of Counseling through their affiliation with Buckner, the researcher had not served as therapist for any of the participants or served in any capacity other than attending events organized by Buckner Children and Family Services, Inc. At the time of the study, the researcher held no authority or influence over the participant. It is the assumption of the researcher that the participants were free to state their beliefs and experiences without any intended or unintended consequence.

In addition, this researcher carefully considered any professional biases or assumptions held before and during the development, data collection, and analyses for this study. The researcher, as Director of Counseling, seeks to better understand the clinical needs of the population the Counseling program serves and to develop a cohesive and evidenced-based program. The researcher was continually self-reflective and mindful to the need to ensure objectivity throughout the phenomenological process. The researcher also considered personal biases and assumptions regarding spirituality. As a Christian, working for a Christian organization, the role of spirituality in the lives of those the researcher and the organization serve requires respectful regard. For professional and personal reasons, the researcher chose a confidential online format for

quantitative and qualitative data collection to reduce the potential for response bias and unintended influence the researcher may have in the participant's responses, particularly as they related to spirituality.

Summary

This mixed methods study was conducted through an online survey utilizing *PsychData* with program participants from Buckner Children and Family Services, Inc.'s Family Pathways program. The survey included demographic questions, questions from the ACEs Questionnaire (Felitti et al., 1998), the Adult Hope Scale (Snyder, 2002), the Resiliency Scale (Wagnild & Young, 1993), the Spiritual Well-Being Scale (Paloutzian & Ellison, 1982), and the Revised Adult Attachment Scale (Collins, 1996). The study examined early childhood adversity, hope, resilience, spirituality, and attachment, looking for relationships between early childhood adversity and these internal protective factors among single parents. In addition, this researcher examined through a phenomenological perspective the participants' unique experiences through five qualitative questions, rather than a single reality (Creswell, 2006). The central purpose of this study was to build quality, strength-based, family and individual therapy services focused on resilience, hope, spirituality, and attachment to strengthen the family.

CHAPTER IV

RESULTS

This online mixed methods study examined the possible relationship between scores on the Adverse Childhood Experiences Questionnaire (ACES-Q) and scores on qualitative instruments concerned with resilience, hope, spirituality, and attachment from the perspective of single parents. Using the quantitative results from the ACES-Q, Adult Hope Scale, Resilience Scale, Spiritual Well-Being Scale, and the Revised Adult Attachment Scale, the scores were compared using correlation analysis to look for positive or negative relationships. In addition, five qualitative questions about the participants' views on their adverse childhood experiences, resilience, hope, and spirituality were asked in the survey. Themes were identified and discussed in this chapter. This chapter includes demographic descriptions, frequencies, procedures, qualitative and quantitative analysis. In addition, supplemental analysis was included related to the participant's length of time in the program, ethnicity, and age.

Sample Frequencies for the Population

In the final sample population for this study, 51 of all possible participants were included, which represented approximately 34% of program participants. All of those who participated in the study were single parents attending a higher educational program and were served through Buckner Children and Family Services, Inc.'s Family Pathways program in the State of Texas. The demographics provided the information that follows:

Age

None of the study participants were younger than the age of 19 or older than the age of 45. As noted in Table 4.1, the majority of the participants were between 30-34 years of age.

Table 4.1

Descriptive Statistics for Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-24	9	17.3	17.3	17.3
	25-29	14	26.9	26.9	44.2
	30-34	16	30.8	30.8	75.0
	35-39	10	19.2	19.2	94.2
	40-44	3	5.8	5.8	100.0

Participants Length of Time in the Program

It was important to look at the length of time the participant spent in the program to compare the scores of resilience, hope, spirituality, or attachment to determine if time spent in the program had a clinically significant impact in hindering or helping the outcome variables (see Table 4.2). In order to have an equal distribution, time in the program over 25 months was condensed into one variable.

Table 4.2

Descriptive Statistics for Length of Time in the Program

		Frequency	Percent
Valid	0-6 months	11	21.2
	7-12 months	11	21.2
	13-18 months	10	19.2
	19-24 months	9	17.3

Ethnicity

The ethnicity of those who participated in this study were 39.2% African American, 23.5% White, 19.6% Hispanic or Latino, and 17.6% identifying as Asian, Native American, Middle Eastern or multi-racial (Multiple). Asian, Middle Eastern, and multi-racial ethnicities, including those who identified as "other," were combined for the purpose of this study so as not to identify the participant by ethnicity, as only one or two participants fell into each of these categories. The study sample was a reasonable representation of the overall ethnic representation of the program (see Table 4.3).

Table 4.3

Descriptive Statistics for Ethnicity

		Frequency	Study Participants Percent	Family Pathways Program (Total)
Ethnicity	White	12	23.5%	34.4%
	Hispanic Latino	10	19.6%	18.6%
	Black African American	20	39.2%	37.7%
	Asian, Middle Eastern or Multiple Ethnicities	9	17.6 %	9.2%

Number of Children

As noted in Table 4.4, the participants reported the number of children in their home so that this researcher could determine if the variable had a significant relationship with the dependent variables.

Table 4.4

Descriptive Statistics for the Number of Children

		Frequency	Percent
Valid	One Child	20	39.2
	Two Children	21	41.2
	Three or more children	10	19.6

Work Status

As detailed in Table 4.5, work status was also evaluated. No one who participated in the study listed 'military' as their work status. Those unable to work may have included anyone who was unable to work due to scholarship or financial assistance requirements, housing requirements, or because of illness or injury.

Table 4.5

Descriptive Statistics for Work Status

		Frequency	Percent	Valid Percent
Valid	Employed	27	51.9	51.9
	Out of work and looking	13	25.0	25.0
	Out of work and not looking	9	17.3	17.3
	Unable to work	3	5.8	5.8

Level of Education Completed and Level of Education Currently Seeking

The participants were asked about the levels of education they had completed and what type of degree they were seeking at the time of the study. All Family Pathways program participants have completed a high school education or equivalent. In addition, 48.1% completed some college; 9.6% completed a trade, technical or vocational program; 30.8% completed an Associate degree; 9.6% had completed a Bachelor's degree; and 1.9% had completed a Master's degree. As noted in Table 4.6, the study participants were currently enrolled in the following: 2% were working on a trade, technical or vocational degree; 47.1% were working on an Associate degree; 37.3% were working on a

Bachelor's degree; 11.8% were working on a Master's degree; and, 2% were working towards a professional degree.

Table 4.6

Descriptive Statistics for Degree Currently Being Sought

		Frequency	Percent
Valid	Trade, technical or vocational	1	2.0
	Associate	24	47.1
	Bachelor's	19	37.3
	Master's	6	11.8
	Professional	1	2.0

Analyses of Quantitative Data

Analyses of Adverse Childhood Experiences

The independent or predictor variable was the overall score for the ACEs Questionnaire (continuous on a scale of 0-10). However, the ACES-Q was also broken into three categorical domains of child abuse, child neglect, and household dysfunction (see Table 4.7). The scores sums were also compared to the national average in Table 4.8. This section will outline the percentiles according to question, domain, and by total score sum.

- Question 1: Fifty percent of those who participated in the survey stated that a parent or other adult in the household swore, insulted, put them down or

humiliated them in some way or made them afraid that they may be physically hurt.

- Question 2: Within the sample, 42.3% stated that an adult pushed, grabbed, slapped or threw something at them or hit them so hard that marks were left or they were injured.
- Question 3: Of those surveyed, 40.4% stated that an adult or household member 5 years of age or older touched, fondled the participant or had the participant touch or fondled them or tried to have oral, anal, or vaginal sex.
- Question 4: Of those surveyed, 51.9% felt that no one in their family loved them or thought they were important or special, or they felt their family did not look out for each other, feel close, or support one another.
- Question 5: Within the sample, 32.7% did not feel that they had enough to eat, had to wear dirty clothes, or had no one to protect them or they felt their parent was either too high or drunk to take care of them or take them to the doctor.
- Question 6: Of the study participants, 61.5% stated that their parents were either separated or divorced.
- Question 7: Of those surveyed, 34.6% stated that their mother or stepmother was often pushed, grabbed, slapped or had something thrown at them or was sometimes or often kicked, hit with a fist, bitten or hit with something hard or ever repeatedly hit of at least a few minutes.

- Question 8: Within the sample, 53.8% lived with someone who was a problem drinker or used street drugs.
- Question 9: Of those surveyed, 38.5% stated they had a household member who was depressed, mentally ill or had attempted suicide.
- Question 10: Of those surveyed, 42.3% had a household member go to prison.

Table 4.7

Family Pathways ACES Scores Compared to Center for Disease Control Study (2016)

ACES Domain	Family Pathways Total	National Total
ABUSE		
Emotional	50%	10.6%
Physical	42.3%	28.3%
Sexual	40.4%	20.7%
Household Dysfunction		
Mother Treated Violently	34.6%	12.7%
Household Substance Abuse	53.8%	26.9%
Parental Separation or Divorce	61.5%	23.3%
Incarcerated Household Member	42.3%	4.7%
Mental Illness	38.5%	17%
Neglect		
Emotional Neglect	52.9%	14.8%
Physical Neglect	32.7%	9.9%

Table 4.8

ACES Score Prevalence

Number of ACES	Family Pathways Participants	National ACEs Scores
0	7.8%	36.1%
1	13.7%	26%
2	7.8%	15.9%
3	9.8%	9.5%
4 or more	60.8%	12.5%

Analyses of Protective Factors

The quantitative analysis examined the correlation between the ACEs, including the domains of abuse, neglect, and household dysfunction, and the scores of resilience, hope, including the Agency and Pathways subscales, spirituality, including the Religiosity and Existential subscales, and the Depend, Close, and Anxiety subscales for attachment. A Pearson product-moment coefficient correlation was used to compare the variables, after coding for missing data. The variables examining age, ethnicity, time in the program, number of children, degree completed, and degree currently being sought were demographic variables that were included in the overall demographic summary but if the participant was missing more than 50% of the survey data, their responses were not included in the analyses. For participants missing less than 50% of the responses, the mean scores were given for the scale or subscale using the mean estimation method in SPSS Statistics 25.

Both the Kolmogorov-Smimov Test and Shapiro-Wilk test were run on the dependent variables but because of the smaller sample, the Shapiro-Wilk test was preferred (see Table 4.9). The Shapiro-Wilks tests were not significant, and, as a result, this study utilized Pearson product-moment correlation coefficient for each analysis.

Table 4.9

Tests of Normality

	Kolmogorov-Smimov			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Hope Mean	0.119	47	0.092	0.962	47	0.127
Hope Agency Mean	0.094	47	.200*	0.947	47	0.034
Hope Pathway Mean	0.161	47	0.004	0.888	47	0.000
Resilience Mean	0.076	49	.200*	0.946	49	0.025
Spirituality Mean	0.118	47	0.105	0.918	47	0.003
Spirituality Religious Mean	0.146	47	0.014	0.889	47	0.000
Spirituality Existential Mean	0.144	47	0.016	0.936	47	0.012
Attachment Anxiety Mean	0.133	47	0.037	0.947	47	0.032
Attachment Depend Mean	0.140	47	0.021	0.975	47	0.395
Attachment Close Mean	0.091	47	.200*	0.979	47	0.532
ACES Mean	0.102	51	.200*	0.948	51	0.027

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Pearson's correlation was conducted to examine the relationship between ACEs Scores, including the scores of the abuse, neglect, and household dysfunction domains, and the RS, HS, RAAS, and the SWBS for the following research questions and hypotheses:

Research Question 1: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Adult Hope Scale?

Null Hypothesis 1a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Adult Hope Scale (see Table 4.10). **The hypothesis was accepted**.

Null Hypothesis 1b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale. **The Pearson correlation revealed that the Adverse Childhood Experiences domain of Abuse had a moderately significant negatively correlated (inversely correlated) relationship with the total Hope score (r = -.321, p = .028) and the subscale, Pathway (r = -.33; p = .026; see Table 4.10).**

Null Hypothesis 1c: There will be no statistically significant relationship between the domain of child neglect scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale. **The hypothesis was accepted**.

Null Hypothesis 1d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale. **The hypothesis was accepted.**

Null Hypothesis 1e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from

the Adverse Childhood Experiences Questionnaire and the scores derived from the Adult Hope Scale when age, race, length of time in the program, or number of children are considered. **The results yielded significance in the demographic variable Ethnicity and the variable, Hope. Hispanic or Latino and Black or African American study participants showed a significant, negative correlation with overall Hope scores and the Hope Pathway subscale (see Table 4.14). In addition, those who had been in the program between 19-24 months scored significantly lower on Hope Pathways subscale (*r* = -.515, *p* = .00).**

Table 4.10

Pearson Product–Moment Correlation between ACEs and ACEs Domains and Hope Scale and Subscales

		Hope Agency Mean	Hope Pathway Mean	Hope Mean
ACEs Abuse Mean	Pearson Correlation	-.275	-.326*	-.321*
	Sig. (2-tailed)	.062	.026	.028
	N	47	47	47
ACEs Neglect Mean	Pearson Correlation	.061	.110	-.003
	Sig. (2-tailed)	.685	.463	.986
	N	47	47	47
ACEs Household Dysfunction Mean	Pearson Correlation	.096	.185	.181
	Sig. (2-tailed)	.520	.213	.225
	N	47	47	47
ACEs Mean	Pearson Correlation	-.047	-.011	-.043
	Sig. (2-tailed)	.752	.942	.773
	N	47	47	47

* Correlation is significant at the 0.05 level (2-tailed).

Research Question 2: Is There a Relationship between Adverse Childhood Experiences Scores and the Scores on the Resilience Scale?

Null Hypothesis 2a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Resilience Scale. **The hypothesis was accepted, as noted in Table 4.11.**

Null Hypothesis 2b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences

Questionnaire and the scores derived from the Resilience Scale. **This hypothesis was accepted.**

Null Hypothesis 2c: There will be no statistically significant relationship between the scores from the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale. **This hypothesis was accepted.**

Null Hypothesis 2d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale**. As demonstrated in Table 4.11, the domain of Household Function revealed a statistically significant relationship with resilience (*r* = .345, *p* = .15). The domains of Abuse and Neglect did not show a statistically significant relationship with Resilience.**

Null Hypothesis 2e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Resilience Scale when age, race, length of time in the program, or number of children are considered. **This hypothesis was partially rejected. When examining the demographic variables, those participants who had been in the program between 19-24 months scored significantly lower on Resilience (*r* = -.385, *p* = .006). The**

number of children a participant had did not have any significance on the scores of Resilience.

Table 4.11

Pearson Product–Moment Correlation between ACES and ACES Domains and Resilience Score

		Resilience Mean
ACEs Abuse Mean	Pearson Correlation	-.224
	Sig. (2-tailed)	.123
	N	49
ACEs Neglect Mean	Pearson Correlation	.109
	Sig. (2-tailed)	.455
	N	49
ACEs Household Dysfunction Mean	Pearson Correlation	.345*
	Sig. (2-tailed)	.015
	N	49
ACEs Mean	Pearson Correlation	.117
	Sig. (2-tailed)	.425
	N	49

Research Question 3: Is there a relationship between Adverse Childhood Experiences Scores and the Score on the Spiritual Well-Being Scale?

Null Hypothesis 3a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores derived from the Spiritual Well-Being Scale. **As noted in Table 4.12, the hypothesis was accepted**.

Null Hypothesis 3b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale. **When**

examining the relationship between Spirituality, including Existential Spirituality and the ACEs domain of Abuse, there was a statistically significant relationship (inverse correlation), as noted in Table 4.12. Those who have endured abuse scored lower in overall Spirituality (*r* = -.36, *p* = .01) and Existential Spirituality (*r* = -.37, *p* = .01).

Null Hypothesis 3c: There will be no statistically significant relationship between the domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale. **This hypothesis was accepted.**

Null Hypothesis 3d: There will be no statistically significant relationship between the scores from the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale. **This hypothesis was accepted.**

Null Hypothesis 3e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores derived from the Spiritual Well-Being Scale when age, race, length of time in the program, or number of children are considered. **When examining the demographic variables, there was a positive, significant correlation between those who had been in the program for 13-18 months and Religious Spirituality (*r* = .38, *p* = .009).**

Table 4.12

Pearson Product–Moment Correlation between ACEs and ACEs Domains and Spirituality Scale and Subscales

		Spirituality Mean	Spirituality Religious Mean	Spirituality Existential Mean
ACEs Abuse mean	Pearson Correlation	-.356*	-.279	-.369*
	Sig. (2-tailed)	.014	.057	.011
	N	47	47	47
ACEs Neglect Mean	Pearson Correlation	-.024	-.050	.008
	Sig. (2-tailed)	.872	.741	.955
	N	47	47	47
ACEs Household Dysfunction Mean	Pearson Correlation	.090	.119	.044
	Sig. (2-tailed)	.548	.426	.769
	N	47	47	47
ACEs Mean	Pearson Correlation	-.111	-.073	-.129
	Sig. (2-tailed)	.458	.628	.386
	N	47	47	47

*. Correlation is significant at the 0.05 level (2-tailed).

Research Question 4: Is There a Relationship Between Adverse Childhood Experiences Scores and the Score on the Revised Adult Attachment Scale?

Null Hypothesis 4a: There will be no statistically significant relationship between Adverse Childhood Experiences Scores and the scores on the Revised Adult Attachment Scale. **The analysis showed a significant, positive correlation between**

the overall ACEs score and the RAAS score of the Anxiety subscale (*r* = .31, *p* = .03; see Table 4.13).

Null Hypothesis 4b: There will be no statistically significant relationship between the domain of child abuse derived from the scores on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale. **Results revealed a strong, inversely correlated relationship with Attachment subscales of Depend (*r* = -.38, *p* = .01) and Close (*r* = -.37, *p* = 01).**

Null Hypothesis 4c: There will be no statistically significant relationship between the scores from domain of child neglect on the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale. **The hypothesis was accepted.**

Null Hypothesis 4d: There will be no statistically significant relationship between the domain of household dysfunction from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale. **The hypothesis was accepted.**

Null Hypothesis 4e: There will be no statistically significant relationship between the scores from the domain of household dysfunction, child neglect, or child abuse from the Adverse Childhood Experiences Questionnaire and the scores on the Revised Adult Attachment Scale when age, race, length of time in the program, or number of children are considered. **The Pearson's correlation results examining the demographic variables (Hypothesis 4e) yielded several significant correlations.**

The number of children and the Attachment subscale of Depend yielded a significant positive correlation (*r* = .34, *p* = .02). There was also a statistical significance between Hispanic or Latino participants the Attachment subscale of Close (*r* = .315, *p* = .03). White participants had a significant correlation with the Attachment subscale Depend (*r* = .30, *p* = .04); and Black or African Americans had a significant correlation with the Attachment subscale Depend (*r* = .32, *p* = .03). Those who had been in the program for 7-12 months were positively correlated with Attachment Anxiety (*r* = .31, *p* = .035), as well as those in the program for 25-30 months (*r* = .30, *p* = .40). Those in the program for 13-18 months positively correlated with Attachment Depend (*r* = .291, *p* = .047). Those in the program 19-24 months positively correlated with Attachment Close (*r* = .31, *p* = .04).

Table 4.13

Pearson Product–Moment Correlation between ACEs and ACEs Domains and Attachment Subscales Anxiety, Attachment Depend, and Attachment Close

		Attachment Anxiety Mean	Attachment Depend Mean	Attachment Close Mean
ACEs Abuse Mean	Pearson Correlation	.273	-.383**	-.372**
	Sig. (2-tailed)	.063	.008	.010
	N	47	47	47
ACEs Neglect Mean	Pearson Correlation	.287	-.280	.233
	Sig. (2-tailed)	.050	.057	.116
	N	47	47	47
ACEs Household Dysfunction Mean	Pearson Correlation	.221	-.061	.054
	Sig. (2-tailed)	.136	.683	.720
	N	47	47	47
ACEs Mean	Pearson Correlation	.312*	-.271	-.064
	Sig. (2-tailed)	.033	.066	.670

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Demographic Analyses

Additional analyses using Pearson's correlation were completed on the demographic variables and the dependent variables. The following variables were entered into analysis: length of time in the program, age, education, number of children, and ethnicity/race to seek relationships with the variables and hope, resilience, spirituality, and attachment.

Length of time in program. One demographic variable, length of time in the program, yielded a significant correlation when compared with the participant scores on Resilience and Hope Pathways. Those who had been in the program between 19-24 months had a strong, negative relationship with Resilience (r = -.385, p = .01), Attachment Close subscale (r = -.31, p = .37) and Hope Pathways subscale (r = -.515, p = .00). Spirituality was insignificant for this group. There was a strong, significant correlation between Religious Spirituality and those who were in the program for 13-18 months (r = .38, p = .01); this group also showed a significant, correlation with Attachment Depend subscale (r = -.30, p = .05). Those who had been in the program for 7-12 months demonstrated a moderate, positive correlation with Attachment Anxiety subscale (r = .31, p = .35).

These results were compared to the ACEs scores and the scores of each of the domains. For those who had been in the program, there was a significant, positive correlation between the domain of Abuse and those who had been in the program for 13-18 months (r = .30, p = .03) and those who had been in the program for 19-24 months (r = .29, p = .04).

Age. When examining age with the dependent variables, those who fell in the 40-44 year old age group showed a significant, negative correlation with attachment anxiety (r = -.30, p = .04). However, no other correlations were noted with ACEs, hope, spirituality, or resilience.

One age group, the 35-39 year group, had a significant, positive correlation with the ACEs domain of Abuse (r = .33, p = .02) and overall ACEs score (r =.32, p = .02). Those who were between the ages of 25-29 years had a negatively correlated relationship with Abuse (r = -. 29, p = .42). The age group of 20-24 had a negatively correlated with the domain of Household Dysfunction (r = -.36, p = .01) and overall ACEs scores (r = -.285, p = .04).

Number of children. There was a significant, positive correlation between those who had three children and the Attachment Depend subscale (r = .340, p = .02). There were no significant correlations with the scores for the hope, spirituality, or resilience when factoring the number of children for the participant. In addition, there was no significance in the analyses between the number of children in the home and ACES-Q scores.

Race and ethnicity. Hispanic or Latino study participants showed a moderately significant, positive correlation with the Attachment Close subscale (r = .315, p = .31) and Hope Pathway subscale (r = .33, p = .04; see Table 4.14). Black or African American study participants correlated negatively with Attachment Depend subscale (r = -.32, p = .03) and Hope Pathway subscale (r = -.33, p = .02). White study participants had a significant correlation with Attachment Depend subscale (r =.30, p = .04). Racial and ethnic groups were also examined with the scores for resilience and the scores of the ACEs. Ethnicity and race did not play a significant role in of ACES-Q or Resilience scores.

Table 4.14

Pearson Product–Moment Correlation between Ethnicity and Adult Hope Scale and Subscales and Attachment Subscales

		Attachment Close	Attachment Depend	Attachment Anxiety	Hope Pathway Mean	Hope Agency Mean
White	Pearson Correlation	-.006	.301*	.018	.139	-.035
	Sig. (2-tailed)	.967	.040	.907	.350	.816
	N	47	47	47	47	47
Hispanic or Latino	Pearson Correlation	.315*	.129	-.263	.328*	.166
	Sig. (2-tailed)	.031	.389	.074	.024	.265
	N	47	47	47	47	47
Black or African American	Pearson Correlation	-.092	-.321*	.231	-.330*	-.117
	Sig. (2-tailed)	.537	.028	.118	.024	.434
	N	47	47	47	47	47

*. Correlation is significant at the 0.05 level (2-tailed).

Analyses of Qualitative Data

Of the 51 participants who completed the quantitative questions, 21 answered at least one qualitative question. The participants had the opportunity at five intervals in the survey to provide additional information that the participants felt would provide more insight regarding their responses or to share about their lived experiences. Research Question 5 asks, "How does the participant view his/her resilience, hope, spirituality, and attachment patterns in relationship to or in spite of their ACEs?" In

addition, each participate was asked, following the inventory questions on *PsychData* for each internal protective factor, if there was anything they wished to share that may have helped or hindered their internal protective factors (resilience, hope, spirituality, and attachment).

Qualitative Research Questions

The questions were as follows:

- Following the ACES-Q: Is there anything else about your childhood that you would like to share?
- Following the questions on resilience: Is there anything else you would like to share that you believe may have helped or hindered your resilience?
- Following the question on spirituality: Is there anything you would like to share that you believe helped or hindered your spiritual beliefs or actions?
- Following the questions on Hope: Is there anything you would like to share that you believe may have helped or hindered your feeling of hope?
- Following the questions on Attachment: Is there anything else you would like to share about your relationships with others, including children, parents, or romantic partners?

Qualitative Themes

The researcher, who served as the primary coder, and the researcher's advising profession, who served as the secondary coder, conducted coding. Of the 51 study participants, 21 participants completed at least one qualitative question. The confidential, online survey allowed for the collection of personal information. In an effort to protect the participants, quotes from data were limited to general statements. In the initial phase of the coding process, each coder reviewed the data separately, which had been manually categorized according the research question, searching for words and descriptors to identify overall meaning (Creswell, 2009). The first four of the five qualitative survey questions asked, "what helped or hindered…." which led many of the responses into one of two categories established by the question. In the second phase of the qualitative coding process, the primary coder and the secondary coder, reviewed the previously agreed upon themes, searching for additional inter-related themes. Through this process, interrelated themes and meaning transpired. When the primary coder and the secondary coder reached 90% agreement, the data were organized accordingly (see Table 4.15).

Table 4.15

Qualitative Categories and Themes

Categories	Strengths-based Themes	Adversity-based Themes
Childhood Experiences	Responsible for self and others	Household Dysfunction (family violence, drug exposure, parental incarceration) Unprotected/Alone
Resilience	Recovery/Sobriety Community Spiritual Faith	No choice (survival) Fear/Stress motivated survival
Spirituality	Personal relationship with God	Historical barriers for/to Religion
Hope	God Counseling Church Support Self-sufficiency	Lack of trust in self and others People are unreliable
Attachment	Children Friendships	Lack of trust. Poor relationship history

Childhood experiences. When responding to the question, "Is there anything else about your childhood that you would like to share," most participants (52%) reported feeling unprotected or alone during their childhood. One respondent stated "I was always

alone…" Household dysfunction included violence, parental alcohol and drug use, parental incarceration, and parental separation. Physical abuse, sexual abuse, and verbal abuse were included in 24% of the narratives. Less than 10% focused on other responsibilities during their childhood to mitigate adversity, such as sibling care or school performance. Fear and stress were expressed by 19% of the respondents, stating, for example, "I never knew what to expect." For those who answered this question, 38% applied reflective insight into how their childhood experiences shaped them, good and bad, past and present. Responses such as included how their childhood experiences led them to excel academically, built resentment, or how through their own experience with addiction and recovery.

Resilience. When asked what may have helped or hindered the participant's resilience, 19% mentioned having no choice. In addition, another 19% stated their children were their primary cause for resilience. One participant stated, "Resilience isn't an option, it's a defense mechanism." Whether resilience was driven by fear or stress, it was not seen as an option. However, respondents also expressed a desire to provide a better life for their child that led them into recovery, to further their education, and to "be someone my child can be proud of." A personal faith in God became another factor in building resilience, with 19% stating faith and a belief in God provided goal-direction, a sense of purpose, and meaning to their life.

Spirituality. None of the respondents equated spiritual faith with religion. All of the participants were able to discern the difference between spirituality and religion and

recognized how those differences impacted their personal beliefs. More than 60% of the respondents expressed having a personal relationship with God. Through the responses, many expressed a renewed sense of faith, a growing faith, or a spiritual discovery following adversity. One participant stated, referring to God, "He has moved in my life so much. And He always has." Several of the participants (14%) stated they had felt betrayed or distrustful of religion or religious institutions, because of either family or religious history. One participant stated, "I am closer to God even though I don't claim to have a religion."

Hope. While the majority saw resilience saw resilience as an internal characteristic, hope was seen as external by a minority of the participants who responded. A parent, child, their children's non-custodial parent, or God were perceived by 38% to be what has helped or hindered their sense of hope. Approximately 19% of the participants identified hope as "suffering," perseverance," or "optimism" with the belief that if one endures the hardship, the hardships will pass, which gave them cause to "hold on."

Attachment. The open-ended question about following the RAAS was similar to the open-ended question regarding childhood experiences. Rather than asking what may have helped or hindered one's attachment, the participant was asked if there was anything else they would like to share about their relationships with others. Again, 47.61% responded with reflection and insight into how their past experiences had created who they are in relationships at this time. "My past has affected how I love…" "What I have

learned about myself…" In addition, 90% of the responses included statements of personal responsibility for past and current relationships. Safe relationships included children, grandchildren, family members, and friends. Thirty percent of the participants believed that God would lead them to the right person at some point in the future. None of the participants expressed being in a current romantic relationship or actively seeking a relationship.

Summary

While the sample of 51 adults represented only 38% of the population (N=151), there was a strong representation across the demographics of age, number of children, length of time in the Pathways program, the degrees completed and the degree sought, and ethnicity. Correlations were made across the demographics and the independent variable of ACEs score, with the dependent variables of resilience, hope, spirituality, and attachment. The correlations also looked at the domains within ACEs of Abuse, Neglect, and Household Dysfunction, as well as the subscales for Attachment, Hope, and Spirituality. A closer look at the domain of Abuse revealed additional significance in relationship to the dependent variables. Additionally, 45% of the 51 respondents completed responses to the five, supplementary, open-ended questions in the survey. The qualitative data was coded into themes which focused on the participants identified strengths and adversities, as a result of their history. This chapter included a detailed discussion of findings and the relationships between the variables, as well as the qualitative data received from the study participants.

CHAPTER V

DISCUSSION, LIMITATIONS, IMPLICATIONS AND RECOMMENDATIONS

The purpose of this mixed methods study was to determine if a relationship exists between the study participants' adverse childhood experiences and their sense of resilience, hope, spirituality, and attachment. While adverse experiences may not cause a lack of resilience, spirituality, or hope, understanding their impact is useful from a clinical perspective to draw on the strengths of clients in the therapy session and to build a therapeutic alliance. People's histories may not define them, but a person's history can shape their health, emotional, relationship, and environmental well-being (Siegel & Hartzel, 2003; van der Kolk, 2014).

This study included participants from Buckner Children and Family Services, Inc. Family Pathways Program, which serves single parents attending college. Of the 57 who accessed the study, the final sample size included 51 respondents who completed 50% or more of the survey questions. For this online, mixed methods study, the use of qualitative questions aligned with the central purpose of the study (Creswell, 2009). Five qualitative questions allowed this researcher to explore the participant's perspective on the events that had occurred in their life and provided the participant with an opportunity to share how those events may have strengthened or hindered them.

Brief Review of Theoretical Framework

What impacts a parent, impacts a child (Calhoun & Tedeschi, 1998; Fonagy et al., 1991; Walsh, 2016). When examining the relationships of childhood abuse, neglect, and household dysfunction with hope, resilience, spirituality, and attachment, it is important to recognize the potential for the intergenerational transmission of stress and trauma. The results from this study highlighted two theoretical concepts. From the perspective of resiliency theory, it can be emphasized that adults who are repeatedly exposed to adversity have the potential to thrive. From the perspective of attachment theory, it can be highlighted that adults who experienced abuse or neglect as children may carry mistrust, anxiety, and a sense of aloneness well into adulthood, shaping not only their relationships with others, but their desire to be in a relationship. Both resiliency theory and attachment theory are relational, underscoring the intraconnectedness and interconnectedness of individuals and their environment (Belis et al., 2017; Richardson, 2002). Yet, as noted in this study, parents who see their history clearly, seek to break unhealthy or harmful familial patterns of behavior and have the potential to change their family's trajectory.

Resiliency Theory

For Browne (2014) and Walsh (2016), resilience is a long-term protective factor when viewed through a lens of significant childhood adversity. The majority (60%) of the participants in this study had experienced multiple adversities. Not all of the study participants viewed resilience as a choice. One participant described resilience as a "defense mechanism," rather than a coping mechanism. However, resilience goes beyond

coping, allowing for recovery from adversity and growth (Walsh, 2016). For the participants who could not rely on a parent to be present or protect them, due to drug use or incarceration, for example, resilience increased when compared to those who experienced abuse or neglect. While resilience helps in the recovery of chronic stress and childhood adversity, developing resilience is not done in isolation but through community support, trusting relationships with others, and familial support, when available (Walsh, 1996). Resiliency development can strengthen families, help families develop more resourcefulness, and build stronger attachment, not only transforming the immediate family but generations to come (Walsh, 2016).

Attachment Theory

Likewise, attachment is not developed in isolation. From the moment a baby enters the world, he or she is reliant on a caretaker for survival. The caretaker may be attuned and sensitive to the baby's needs, or not. Attachment shapes the way one sees the world and sees themselves, or their internal working model as safe or unsafe, lovable or unlovable, or worthy or unworthy (Atwool, 2006; Bowlby, 1969; Ungar, 2004). For the participants in this study, their early attachment experiences shaped their adult relationships. Some recognized this pattern and were able to express how their history shaped their ability to love and be loved, by either pushing people away, "needing constant reassurance," or fearing abandonment. The qualitative responses were congruent with the quantitative findings, as follows: with increased childhood adversity, there was an increase in attachment anxiety and with an increase in child abuse, there was a

decrease in one's ability to depend on others in times of need and to feel comfortable with closeness. However, attachment security can be obtained in spite of adversity (Siegel & Hartzel, 2003; Sroufe & Siegel, 2011). Attachment healing is an important element in building resiliency. The cycle of attachment has an intergenerational impact, but change is always possible, attachment security is obtainable, and attachment security should be a continual, clinical focus (Sroufe & Siegel, 2011).

Discussion of Findings

Protective factors aid in the recovery of stress, chronic stress and trauma and foster positive outcomes in spite of adversity (Browne, 2014; Ungar, 2004). The population in this study had endured much more abuse, neglect, parental and household dysfunction than the national average and higher than comparable samples in studies on high risk, low-income, urban populations, both internationally and domestically, excluding those who were incarcerated or in/aged out of foster care due to abuse and/or neglect (Halfon et al., 2017; Soares et al., 2016). Although some researchers differentiate between adversity, trauma, and chronic stress experienced in childhood, it can be said that all three experiences change neurological and biological well-being well into adulthood (Leitch, 2017; van der Kolk, 2014).

Hope

Hope provides individuals with the ability to set and meet goals through a held belief that their lives will improve with determination and energy (Snyder et al., 1991a). However, for those who have faced significant adverse childhood experiences, hope may

be an elusive protective factor. Yet, hope can also be born from adversity and the desire for a better outcome (Snyder et al., 1991a). According to Snyder (1991b), there are two ways in which people expressed hopefulness; through processes, or "workable routes" to solve the challenge before them (Pathway), and with an enthusiasm or motivation to assume the best will happen (Agency). Agency is goal-directed. Pathway is able to create the plan to meet those goals (Snyder et al., 1991b). In this study, participants who had experienced verbal, physical, or sexual abuse scored lower in Hope Pathway, finding it more difficult to find workable routes to solve problems. While the study participant may have the desire to move forward, they may tend to be stuck on which direction to move, or how to get there. Seeing a workable solution may be the most challenging obstacle facing those who have had so few options. Agency may be what brought them to the Family Pathways program, but Pathway may be what the participant both needs, yet struggles with.

From a qualitative perspective, hope and spirituality were often aligned. "I knew God would help me," or "I have to give it to God" were statements associated with hope and congruent with other qualitative studies on hope following adversity (Hall et al., 2009). Research consistently delineates the impact of childhood abuse on adult outcomes, including self-injurious behaviors, suicide attempts, eating disorders, and substance abuse, highlighting the adverse-based qualitative themes demonstrating a lack of trust in oneself, a lack of reliance on others to be there in times of need, and the feeling of aloneness, or "numbness," as one participant described it, from the chronic stress of

multiple adverse childhood experiences (Anda et al., 2006; Dube et al., 2001; Dube et al., 2003).

Hope is an important element in moving those forward who have faced adversity. This study pointed out that those who have experienced childhood adversity or maltreatment may have the motivation and desire for a better tomorrow. However, their ability to follow through on tasks to obtain their goals may be compromised. Nwoye (2011) looked at hope from a psychological and therapeutic perspective which, using Snyder's Hope theory, emphasizes the importance of helping program participants by talking through goals, and identifying reachable, manageable tasks to help meet those goals. As a result, therapeutic alliances should focus on interventions that help develop strategies for problem solving to help align the individual's desire for change with their capacity for creating change (Snyder et al., 1991a).

Resilience

The relationship of Household Dysfunction and resilience is an understudied area in social research. In a Swedish study, there was a graded response between childhood household dysfunction (including parental illness and death, public assistance receipt, and residential instability) and self-harming behaviors (Björkenstam et al., 2016). Another longitudinal study examined resiliency and recovery in adulthood for children who had been reared with poverty, perinatal stress, parental psychopathology, chronic discord, or parental divorce. Personal characteristics, such as affectionate and compliant, protective factors in the family, such as one reliable caregiver, and protective factors in the

community, such as a teacher, pastor or neighbor, provided opportunities for recovery in adulthood (Werner, 2005). As noted in the qualitative responses of the participants in this study, resilience is not always a process of choice, but of survival. Those who face adversity were thrust into the position of sink or swim. The qualitative narratives also centered on resilience as a community and faith based effort. Although the participant may have felt alone in childhood and felt resilience was not an option, the desire to have a community of support to build resilience was present in the qualitative narratives of the participants. These statements were consistent with other qualitative studies that examine resilience in relationship to adversity (Hall et al., 2009; Pressley & Smith, 2017).

Yet, the quantitative analyses showed those with higher adversity in the area of household dysfunction had greater resilience. Household dysfunction includes family systems adversity, such as living with a household member who was mentally ill, incarcerated, had parents who were separated or divorced, witnessed domestic violence of a mother or step-mother, or had a household member who was a problem drinker or used street drugs (Felitti et al., 1998). However, even within the domain of household dysfunction, there may be tremendous differences in the resilience of one whose parents were separated and divorced than someone who was repeatedly exposed to domestic violence. Sabina and Banyard's (2015) examination of resilience following a history family violence focuses on the importance of the broader community support, economic development, and increased services, which in turn, can lead to a second-order change in reducing poverty and increasing opportunities for the next generation.

Also noted in this study, resilience declined slightly among participants who had been in the program for 19-24 months. Although a myriad of factors could contribute to this, those providing services cannot check resilience off as something "achieved." Building a capacity for resilience is not only about reducing risk, but promoting continuous and long-term overall wellbeing (Sabina & Banyard, 2015).

Spirituality

Previous research has established that change in religiosity and spirituality occurs following traumatic incidents (Falsetti et al., 2003). However, numerous studies have also demonstrated that existential and religious wellbeing, related to psychosocial wellbeing, can improved immune function, lower health-risk behaviors, improve coping behaviors, lower heart rate, and reactivity across multiple cultural and racial groups (Falsetti et al., 2003; Koenig, 2012; Paloutzian, 2017). Existential Spirituality targets one's sense of purpose for one's life and overall well-being, while Religious Spirituality targets one's relationship with God (Paloutzian & Ellison, 1982). In this study, those who had a childhood history of physical, sexual, and verbal abuse had lower overall spirituality and lower sense of purpose for one's life (existential).

The qualitative data from this study demonstrated that, although abuse may impact one's religiosity or their participation in organized religion, many participants felt they could not have survived difficult times without their faith or a belief that God was looking out for them. It is important to note that this outcome is not an effort to emphasize pro-religious or spiritual behavior but to consider, from a clinical perspective,

how an individual perceives himself or herself based upon their personal, spiritual beliefs and in light of their adversity. From the qualitative and the quantitative data collected, the meaning participants placed on religion and faith went much deeper than religious practices, shaping the way one faced ambiguous and uncertain futures (Paloutzian, 2017). One participant stated their faith was a constant and intentional process, as addiction had been for them in years prior. For those who have a belief in God, a healthy perspective of one's self in relationship with God can provide additional positive coping and hope through adversity (Koenig, 2012).

Attachment

Attachment theory has been studied in relationship to childhood experiences, parenting, and intergenerational patterns of adversity, as attachment security influences feelings, behaviors, and thoughts about self and others (Ainsworth & Bowlby, 1991; Collins, 1996; Collins & Read, 1990). Babies seek comfort and safety from their early attachment figure (Bowlby, 1957). This study confirmed that the quality of the participant's relationship with their parent impacted their ability to feel safe and to trust others to meet their needs. It was important in this study to examine whether the participant believed they could depend on others to be available when needed, how they perceived being loved or rejected, and whether they felt comfortable with intimacy and closeness, in relationship to or in spite of their childhood relationships. Overall, those who were physically, sexually, and verbally abused struggled with depending on others and being close to others.

The qualitative responses demonstrated that those who have experienced abuse and neglect tend to avoid closeness in relationships because it may increase feelings of vulnerability and is perceived as a threat, rather than an act of love, underscoring that attachment security not only shapes the way in which one views stressful events but also how stressful events shape the individual (Ainsworth & Bowlby, 1991). Research in the area of abuse and attachment affirms this fear and informs clinical practice on the intergenerational impact of attachment insecurity and disorganized attachment (Hesse & Main, 2000; Sroufe, 2005). In addition, those who faced greater adversity also had greater anxiety in relationship with others. The qualitative responses highlight research on children who sense their parent's anxiety and hesitation and, as a result, become fearful that their needs will not be met (Sroufe & Siegel, 2011). From an intergenerational standpoint, an anxious parent will doubt their ability to meet their child's needs or may feel they are unworthy of love and consistent care. Several of the participants stated their fear of being close to others, fear of being hurt, or fear of being rejected. There were also expressions of mistrust in themselves, questioning whether they could adequately discern healthy or safe relationships.

Limitations of the Research

Several limitations in this study need to be addressed. First, a criticism of the ACEs Questionnaire is that the answers are reflective and the experiences cannot be verified (Hardt & Rutter, 2004). Some studies report that retrospective reporting of abuse in adulthood can yield a false negative or a false positive, as an adult may recall or

repress childhood memories (Hardt & Rutter, 2004). For the purpose of this study, confirmation of levels or experienced abuse, neglect, and household dysfunction was unnecessary because this author sought to examine how the participants perceived their internal protective factors in relationship to childhood adversity, not to validate the adversity itself. There was nothing about the study that would have encouraged the participant to present a more positive or negative picture of their childhood experiences.

A second limitation for this study is the small sample size, which limited the statistical analysis to correlation and descriptive statistics. The average monthly census during data collection allowed for approximately 134 possible participants. However, the results of this study are generalizable.

Launching this study, the researcher sought other organizations that were providing services that would meet the criteria for the Strengthening Families Protective Factors. No other non-profit, Christian organizations were located that provided residential, educational, counseling, and support services. The goal of this study was to examine the relationship between adverse childhood experiences and one's resilience, hope, spirituality, and attachment. Examining these protective factors for those who are living independently or who are homeless, for example, may yield very different results. For that reason, the decision was made to use a small sample, rather than increase the demographic variables.

There were several limitations related to the qualitative data collection as a result of the confidential, online data collection. While completing an online survey is efficient

for study participants, it did not provide the personal, one-on-one dialogue that may have provided rich, more detailed experiences through a face-to-face interview. In addition, the participants shared personal, potentially identifying information that could not be shared in this study in order to protect the identity of the sample. However, the anonymity of the online format reduced the potential for response-bias, which may have been a factor as this researcher serves as Director of Counseling for Buckner Children and Family Services, Inc.

Clinical Implications

Strength-based Counseling

While there has been tremendous research in the area of adversity, trauma, and healing, there is still so much to learn, particularly through the eyes of those we serve. There is tremendous wisdom gained from recognizing how a parent views their own internal protective factors that have either propelled them forward or held them back. Drawing on one's strengths in therapy is not a new construct (Gelso & Fretz, 2001; Kaczmarek, 2006). However, therapy is not often sought, voluntarily, when parents are short on financial resources and distrustful of an institution and society that stigmatizes mental illness and over-pathologizes (Bailey, Patel, Barker, Ali, & Jabeen, 2011; Merten, Cwik, Margraf, & Schneider, 2017). When non-profit, social service organizations have limited resources, limited opportunities to build a therapeutic alliance, and serve a diverse group of program participants in need of support, it becomes imperative to consider how

the participant views their own resilience, hope, spirituality, and attachment in light of their adverse childhood experiences and draw upon their strengths.

Using the ACES-Q

Research has consistently demonstrated the use and need for the understanding the adversity in which a population receiving services has experienced. The Adverse Childhood Experiences Questionnaire can be an important tool for service providers, including mental and behavioral health care providers (Leitch, 2017; Murphy et al., 2014). While many social service organizations may be operating from an anecdotal account of their population, there are tremendous differences, as this study noted, in how protective factors are impacted by the one's adversity. Yet, not all adversity is equal, and everyone has a different community and intergenerational experience. Parental drug use may increase perceived resilience while sexual abuse may negatively impact an individual's ability to develop a close, intimate relationship with others. As previous research has determined, however, accumulated adversity is significant and has to be viewed by social service and therapists from a multi-dimensional model, such as the Strengthening Families, Protective Factors model (Browne, 2014). Understanding the research on the graded relationship between abuse, neglect and household dysfunction helps to providers wrap layers of support to minimize potential risks, identify paths for healing, and stabilization, while also acknowledging the strengths and internal protective factors a program participant may have.

It was also noted that participants who experienced greater Household Dysfunction perceived themselves as resilient. It is important from a clinical and

attachment perspective to note whether resilience may be due to early parentification. In households where caregivers abused drugs or alcohol or suffered from a mental illness, for example, a child may learn that the parent is unavailable and may require assistance from the child. While this early parentification does not always manifest itself into attachment anxiety, anxiety can become an underlying response for a child who has no adult to turn to for his or her own needs (Hooper, 2007). Further research in this area may be useful to determine a correlation between parentification and Attachment Anxiety (George, Kaplan, & Main, 1995; Hooper, 2007). In addition, it may be necessary to explore in counseling whether resilience is a help or a hindrance. For those who have had little choice in childhood but to bend and bounce back following adversity, there may be an underlying fear of grieving a loss, speaking one's mind, or standing firm in one's values and beliefs (Boss, 2006). Resilience should not equate to passivity.

Hope Pathway as a Clinical Goal

As mentioned previously, a participant may express hope in the future, but may not have the Pathway needed to complete tasks, meet objectives, and accomplish goals. This was an important clinical finding as service providers often view program participants as lacking motivation to change their circumstances when they may not possibly have the Pathway to do so. Utilizing Nwoye's (2011) perspective and Snyder's Hope theory (2002) of those who have endured tremendous adversity, encourages providers to view work collaboratively with program participants by talking through goals, and identifying reachable, manageable tasks to help meet those goals. Like

resilience and attachment, hope can also be developed through relationships. Mentoring and modeling can help those who are struggling with Hope Pathway learn workable solutions (Nwoye, 2011).

Attachment Security

Attachment security is an important piece of this study. Numerous studies have shed light on the correlation between psychopathology and attachment insecurity (Dube et al., 2001; Dube et al., 2003; Hesse & Main, 2000; Main, 1996). Schore (2014) refers to psychotherapy as a right brain to right brain interaction. Trust, safety, and attunement are important elements in helping clients process their history, see their histories clearly, and regulate their emotions when faced with critical or stressful situations (Sroufe & Siegel, 2011).

To provide program participants with opportunities to process unresolved loss or trauma, to develop a coherent, truthful narrative of one's history, and to develop attachment security not only benefits the program participant but also could possibly change the trajectory for their children. For those working with at populations in which trauma, histories of abuse, adverse childhood experiences, psychopathology, or parenting stress are key components, knowledge and training of the Adult Attachment Interview (AAI), combined with self-reported attachment inventories have the potential to be life-changing (Cassidy et al., 2013).

In addition, Murphy et al. (2014) states in the study examining adversity in relationships that attention needs to be given to positive relationship experiences. By

asking individuals about childhood relationships in which they felt protected, loved, or special has clinical value when assessing attachment security, and possibly resilience in adulthood following ACEs (Murphy et al., 2014). Research continues to expand in the area of evidenced-based practices that best build resilience and focus on increasing internal protective factors for those who have experience adversity in childhood.

Neuroeducation

Finally, another area of importance is neuroeducation with populations who have experienced significant adversity. Abuse, neglect, and household dysfunction can impact social functioning, emotional and physical reactivity, and impaired cognitive and relational functioning, making it difficult to use sequential, plausible routes to achieve goals (Anda et al., 2006; Perry, 2002; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Tomoda et al., 2011; van der Kolk, 2014). Research confirms the increased use of alcohol, illicit drugs, and nicotine in those who have experience greater adversity, and those with PTSD symptoms. Therapeutic providers have the opportunity to discuss these risks, discuss the relationship between PTSD symptoms, stress and adversity and substance abuse in light of the client or program participant's drug of choice. By understanding the neurobiological impact of adversity, therapists can help program participants become responsive, rather than reactive (Jovanovic et al., 2009; Leitch, 2017).

Recommendations for Future Research

Racial Trauma as an Adverse Childhood Experience

Further study is recommended regarding the impact of racial trauma as an adverse childhood experience, particularly in relationship to the internal protective factors of hope, resilience, spirituality, and attachment. In this study, Hispanic/Latino and Black/African American study participants showed a significant, negative correlation with overall Hope scores and the Hope Pathway subscale. Black/African American participants also had a significant, negative correlation with Attachment Depend subscale. Hispanic/Latino participants had a significant, positive correlation with Attachment Close subscale. This study did not seek to explore racial differences further but this researcher believes one's racial identity, cultural history, and experiences with racism and discrimination are important, therapeutic elements.

Program Fatigue

Additionally, there was a decrease in resilience and Hope Pathway among participants who had been in the program for 19-24 months. While this may have been circumstantial, it is important for program staff to be attuned to decreases in resilience when delivering services over extended periods of time. Increasing support, increasing relational interaction, and being mindful of vulnerabilities, can help decrease the possibility of the participant sabotaging program goals, relapsing from substance abuse or alcohol abuse, and decrease parenting stress.

Summary

This purpose of this study was to investigate the internal protective factors of hope, attachment, resilience, and spirituality identifying clinical needs and areas of clinical growth of parents participating in a nonprofit program. Utilizing the Strengthening Families Approach and Protective Factors Framework from the Center for the Study of Social Policy, the goal for this study was to more fully understand how ACEs correlate with internal protective factors and to gather, from the perspective of the study participant, how they perceive the protective factors that have seen them through difficult times.

This mixed methods study examined the relationship between the study participant's ACEs scores and scores on inventories that measured resilience, hope, spirituality, or attachment. The study participants were program participants of Buckner Children and Family Services, Inc. Family Pathways Program that serves single parents attending a higher educational program. The final sample of 51 respondents completed an online quantitative survey and 23 of the 51 responded to the five qualitative questions. Over 60% of respondents had an ACEs score of 4 and higher, placing them at greater risk for a range for emotional and health related risks. Not only were the total ACE scores compared with the internal protective factors, but the domains within the ACE of abuse, neglect, and household dysfunction, were also compared.

Overall, as ACE scores went up, Hope scores and the subscale, Pathway, lowered. Those who experienced abuse in childhood, whether it was physical, sexual, or verbal,

had significant, negative correlations with Hope, Hope Pathway, Spirituality, including Existential Spirituality, and the Attachment categories of Depend and Close. Abuse had a positive correlation with Attachment Anxiety. In addition, those who scored higher in the domain of Household Dysfunction scored higher in Resilience. The qualitative data revealed themes of a personal relationship with God and strength, but also a sense of aloneness and a lack of trust.

Organizations and clinical providers are encouraged to use interventions and techniques that draw on the participant's strengths and target the family's long term needs to promote healthy family functioning, not just for the immediate family, but also for the generations to follow.

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APPENDIX A

Bucker International History Services

A Legacy of Hope

From its inception, Buckner was founded on the principle that what many people need is hope. It's what drove Buckner Founder R.C. Buckner, a Baptist minister to begin his work caring for orphans.
At a meeting of Texas Baptist deacons in 1877, Buckner sponsored a resolution to begin an orphans home as soon as $2,000 could be raised. Those present that day named him the fund-raising agent for the project. Dr. Buckner collected his first funds, $27, when he passed a hat among "fellow brethren" visiting under the shade of an oak tree. The first dollar given was his very own. By the end of 1879 he had collected $1,200, which he supplemented with a personal bank note. On April 9, 1879, a charter was filed with the Secretary of State and in December of the same year, Buckner rented a small cottage in East Dallas to care for the first three orphan children.

Within two years, Dr. Buckner had purchased 44 acres six miles east of Dallas, where Buckner Children's Home still operates today.

A vast vision

Even from those earliest days, the vision of R.C. Buckner was far beyond just the accumulation of land and the building of structures. His was a vision for helping children and families put together the broken pieces of their lives. For Buckner, that meant more than simply housing those who were homeless.

Buckner was heavily involved in community and state affairs. In 1877, he founded the first high school in North Texas for African-Americans. He was instrumental in establishing the Dallas Humane Society and served as its president. He founded Children's Hospital in Dallas in 1894, and he was one of the driving forces behind the opening of Baptist Memorial Sanitarium, now Baylor Healthcare System, serving as president of the board from 1904-1908.

While the 136-year journey of Buckner International has not always been easy, it has been constantly rewarding. Along the way, the ministries of Buckner have picked up the downhearted and reached out to countless thousands of hurting humanity. To that end, Buckner has continued to grow and expand under the leadership and vision of those who have led the organization.

A diverse ministry

Today, Buckner is one of the largest and most diverse private social care agencies of its kind in the nation. Under the leadership of Dr. Albert L. Reyes, the organization's sixth president, Buckner is a vastly diversified ministry dedicated to transforming the lives of vulnerable children, enriching the lives of senior adults and building strong families through Christ-centered values.

The organization's commitment to searching out opportunities for ministry has led Buckner to develop programs and services that reach deeply into every corner of our society. Our four focus areas of ministry are:

- Foster care --Providing families for abused, abandoned or neglected children.
- Family transition ministries --Helping families stay together by providing single mothers seeking higher education with affordable housing and support.
- Buckner Family Hope Centers --Preserving families by providing them with critical social services and aid to keep them strong. Families are restored and empowered through intensive case management.
- Buckner Retirement Services –Providing a distinctive senior lifestyle.

APPENDIX B

Buckner Letter of Approval to Conduct Research

BUCKNER®
Hope shines here.℠

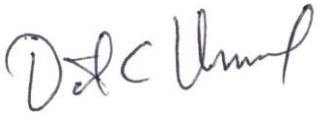
November 27, 2017

Dear Amy Curtis,

As a doctoral candidate, you have requested permission to survey the program participants in Buckner Children and Family Services, Inc.'s Family Pathways program. The title of the study "Strengthening Families: The Relationship between Hope, Spirituality, Resilience and Attachment among Parents Following Adverse Childhood Experiences," will include an anonymous online survey consisting of four measurements scales and a short, non-identifying demographic survey. This survey will be available to approximately 144 participants currently in the program across the State of Texas. Participation in the study will be completely voluntary.

I support this effort and will provide any assistance necessary for the successful implementation of this study and the protection of the participants. If you have any questions, I can be reached at (903)757-9383.

Sincerely,



David C. Ummel, D. Min., LCPAA

Senior Executive Director for Preservation Programs

Buckner Children and Family Services, Inc.

Buckner Children and
Family Services, Inc.

1014 S. High Street
Longview, TX 75602

Phone (903) 757-9383

www.buckner.org

APPENDIX C

Institutional Review Board Approval Letter

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: April 4, 2018

TO: Ms. Amy Curtis
Family Sciences

FROM: Institutional Review Board (IRB) - Denton

Re: *Approval for Strengthening Families: The Relationship between Hope, Spirituality, Resilience, and Attachment among Parents Reporting Adverse Childhood Experiences (Protocol #: 19993)*

The above referenced study was reviewed at a fully convened meeting of the Denton IRB (operating under FWA00000178). The study was approved on 4/3/2018. This approval is valid for one year and expires on 4/3/2019. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A request to close this study must be filed with the Institutional Review Board at the completion of the study. Because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the IRB is not required.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Jerry Whitworth, Family Sciences
Dr. Linda Ladd, Family Sciences
Graduate School

APPENDIX E

Invitation to Participate in Study

Hi Family Pathways Participant,

I am conducting a study with parents who have or are currently participating in Buckner Children and Family Services, Inc. Family Pathways Program.

The study is *Strengthening Families: The Relationship between Hope, Spirituality, Resilience and Attachment among Parents Reporting Adverse Childhood Experiences*. You are invited to participate in a study that will examine the relationship between childhood experiences and how well you bounced back from these experiences, how much your faith helped or hindered you, how hopeful you may be looking to the future and how early childhood experiences may have impacted your relationships with others today.

This study, involving one, one-hour survey conducted anonymously online, is being conducted by Amy Curtis with Texas Woman's University for completion of her doctoral degree in Family Therapy.

Compensation is available. If you would like more information about participating in the survey, please contact Amy Curtis at 817-xxx-xxxx.

To access the survey or read more about the survey, please click:

https://www.psychdata.com/s.asp?SID=181517

Sincerely,

Amy Curtis

APPENDIX F

Recruitment Flyer

Family Pathways Participants Needed

for Research Study

STRENGTHENING FAMILIES: THE RELATIONSHIP BETWEEN HOPE, SPIRITUALITY, RESILIENCE AND ATTACHMENT AMONG PARENTS FOLLOWING ADVERSE CHILDHOOD EXPERIENCES

You are invited to participate in a study that will examine the relationship between childhood experiences and how well you bounced back from these experiences, how much your faith helped or hindered you, how hopeful you may be looking to the future and how early childhood experiences may have impacted your relationships with others today.

This study is being conducted by Amy Curtis with Texas Woman's University for completion of her doctoral degree in Family Therapy.

The study involves one, one-hour survey conducted anonymously online.

Compensation available.

If you are at least 18 years old and are a current participant in Buckner Children and

Family Services, Inc.'s Family Pathways Program and would like more information

about participating, contact:

Amy Curtis at 817-xxx-xxxx or through www.PsychData.com

APPENDIX G

Consent to Participate in Research

Consent to Participate in the Study

You are being asked to participate in an online research study on the relationship between spirituality, attachment, hope, and resilience for those who have experienced adversity in their childhood. A goal of the study is to strengthen services offered to single parents. Only Buckner's Family Pathways program participants are being asked to participate in this online study. As a participant, your experiences and your insight are crucial to the services developed at Buckner. Your email was provided to this researcher, who is also an employee of Buckner Children and Family Services, Inc., from the Family Pathways Program database..

Please read this consent form carefully and ask any question that you may have before agreeing to participate. You have the right to ask questions about this research study and to have those questions answered by the researcher before, during or after the research. If you have any questions about the study, at any time feel free to contact the researcher, Amy L. Curtis at acurtis1@twu.edu. If you have any other concerns about your rights as a research participant that have not been answered by the researcher, you may contact Dr. Linda Ladd, professor with the Family Therapy program at Texas Woman's University at lladd@twu.edu.

Purpose of Study

Many have faced difficulty in their childhood. Two people who have faced the same experiences may respond very differently. Some may thrive, while others struggle to make sense of what has happened to them. The purpose of this study is to look at four of the factors that may help or hinder people following the difficulty they have faced: hope, resilience, spirituality and attachment. More importantly, agencies and professionals want to know how each individual views the challenges they have faced and how those challenges may impact the four factors. If someone has had more adversity, does their faith lessen? Does the type of adversity (abuse, for example) impact a person's resilience more than other types of adversity? This study will examine the relationship between these four factors and adversity in childhood.

Defining adversity in childhood in this study will be aligned with the Adverse Childhood Experiences Questionnaire and Study from 1997, which consists of ten questions. These ten questions will ask about abuse, neglect and challenges that may have existed in your household, such as a person living in the home who may have struggled with drugs or alcohol, or a parent who may have been incarcerated during your childhood.

Description of the Study Procedures

If you agree to participate in this study, you will then continue to the next page to begin answering the survey questions. The study will take no more than 45-60 minutes to complete. Your answers are confidential. Your email address will not be associated with your responses and they will be kept separate from your data to protect your identity.

You are encouraged to find a comfortable environment where you can complete the survey without interruption and where you will be able to sit for an extended period of time. You are also encouraged to find a location that is private so your answers remain confidential.

Risks/Discomforts of Being in this Study

- Coercion: There is a potential that you will feel influenced or pressured by Buckner Children and Family Services, Inc to participate in this research study. At no time will Buckner program staff be asked to recruit participants for this study and the staff will be notified of the importance of not coercing or offering an incentive to you to take part in this study. This researcher will make every effort to protect you from pressure or influence to participate in the research study, so you are participating freely, without influence.

- Emotional discomfort, including anxiety: The questions in this study may cause emotional discomfort. You may withdraw from the study at any time without penalty. You may also skip questions you do not wish to answer. At the end of the survey, you will be provided a list of therapeutic resources to contact should you experience any physical or emotional discomfort while taking the survey. You may also access the Family Pathways Counselor at your location, where available. TWU is not responsible for providing you with medical services or financial compensation following this study.

  If you are currently seeing a counselor or therapist, you are encouraged to contact them if you experience any emotional distress while taking this survey. You may also access counseling through the following:
  - American Psychological Association Psychologist Locator: https://locator.apa.org/
  - National Board for Certified Counselors: http://www.nbcc.org/Search/CounselorFind
  - Therapist Locator: https://www.aamft.org/iMIS15/AAMFT/Content/directories/locator_terms_of_use.aspx

- Find a Therapist: https://www.networktherapy.com/directory/find_therapist.asp

- Fatigue: You may experience fatigue due to the potential length of the study (45-60 minutes). To minimize the risks of fatigue or discomfort, you may stop and stretch at any time or take a break from the study. Your responses, however, cannot be saved. Therefore, if you exit the survey, you will lose your completed responses.

- Loss of Confidentiality: There is a potential risk of loss of confidentiality with any internet transactions. The survey data will be kept separately from the addresses and/or email addresses which will be stored in a locked filing cabinet in this researcher's home or office. The researcher will not be collecting or retaining any information about your identity. The data collected in this study will be non-identifying. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password protected file. The researcher will not include any information in any report that may be published that would make it possible to identify you

- Loss of Time: This survey will take no more than 45-60 minutes to complete. You may withdraw from the study at any time without penalty.

Benefits of Being in the Study

Your participation in this study will help agencies and organizations who support and strengthen families understand how adversity impacts one's spiritual beliefs, their sense of hope about the future, their resilience (ability to bounce back after facing difficulties) and how they love and trust others following adversity (attachment). Regardless of whether you have faced a difficult childhood or a happy childhood, your experiences will help agencies and professionals know how to best meet the clinical needs of those served.

At the end of this study, there are directions for how to receive an executive summary of this study and if you wish to receive the $25 gift card provided for participants who complete the study. This will require that you provide the researcher with your address and email, which will result in the loss anonymity. However, this researcher will keep

your address and email address separate from your online survey responses. This researcher will send you the gift card via mail or to your email address.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may choose to withdraw from the study *at any time* without affecting your relationship with the researcher or Buckner Children and Family Services, Inc. Your decision will not result in any loss or benefits to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely from the survey at any point during the process.

Right to Report Concerns

If you have any problems or concerns that occur as a result of your participation, you can report them to the Dr. Linda Ladd at the number above. Alternatively, concerns can be reported by contacting the Institutional Review Board at Texas Woman's University, irb@twu.edu or (940) 898-3378.

Consent

When you have read this consent form, please check the box at the bottom of the page which indicates that you have read the form. By clicking on the following page, you indicate that you have agreed to volunteer as a research participant for this study, and that you have read and understood the information provided above. By progressing to the next page, you are providing consent to participate in the study. If you wish, please print of a copy of this consent for your records.

If you elect to voluntarily participate in this study, please check the box and then continue.

If you proceed beyond this page, it is presumed that you are giving permission to be in this study

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APPENDIX H

Demographic Questionnaire

Demographic Questions

Age: What is your age?

- 18-24 years old
- 25-29 years old
- 30-34 years old
- 35-39 years old
- 40-44 years old
- 45-50 years old

Ethnicity origin (or Race): Please specify your ethnicity.

- White
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian / Pacific Islander
- Other

Education: What degree are you seeking?

- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree

Employment Status: Are you currently…?

- Employed for wages
- Self-employed
- Out of work and looking for work
- Out of work but not currently looking for work
- Military
- Unable to work

Household members: How many are currently living in your home?

- Two
- Three
- Four
- More than four

APPENDIX I

Adverse Childhood Experiences Questionnaire

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____

4. Did you **often** feel that …
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____

5. Did you **often** feel that …
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

APPENDIX J

Resilience Scale

Resilience Scale™

Date_____

Please read each statement and circle the number to the right of each statement that best indicates your feelings about the statement. Respond to all statements. Circle the number in the appropriate column	Strongly Disagree						Strongly Agree
1. When I make plans, I follow through with them.	1	2	3	4	5	6	7
2. I usually manage one way or another.	1	2	3	4	5	6	7
3. I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4. Keeping interested in things is important to me.	1	2	3	4	5	6	7
5. I can be on my own if I have to.	1	2	3	4	5	6	7
6. I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7. I usually take things in stride.	1	2	3	4	5	6	7
8. I am friends with myself.	1	2	3	4	5	6	7
9. I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10. I am determined.	1	2	3	4	5	6	7
11. I seldom wonder what the point of it all is.	1	2	3	4	5	6	7

12. I take things one day at a time.	1	2	3	4	5	6	7
13. I can get through difficult times because I've experienced difficulty before.	1	2	3	4	5	6	7
14. I have self-discipline.	1	2	3	4	5	6	7
15. I keep interested in things.	1	2	3	4	5	6	7
16. I can usually find something to laugh about.	1	2	3	4	5	6	7
17. My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18. In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19. I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20. Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21. My life has meaning.	1	2	3	4	5	6	7
22. I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23. When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24. I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25. It's okay if there are people who don't like me.	1	2	3	4	5	6	7

APPENDIX K

Adult Hope Scale

Adult Hope Scale (taken from http://www.ppc.sas.upenn.edu/hopescale.pdf)
Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1. = Definitely False
2. = Mostly False
3. = Somewhat False
4. = Slightly False
5. = Slightly True
6. = Somewhat True
7. = Mostly True
8. = Definitely True

___ 1. I can think of many ways to get out of a jam.
___ 2. I energetically pursue my goals.
___ 3. I feel tired most of the time.
___ 4. There are lots of ways around any problem.
___ 5. I am easily downed in an argument.
___ 6. I can think of many ways to get the things in life that are important to me.
___ 7. I worry about my health.
___ 8. Even when others get discouraged, I know I can find a way to solve the problem.
___ 9. My past experiences have prepared me well for my future.
___10. I've been pretty successful in life.
___11. I usually find myself worrying about something.
___12. I meet the goals that I set for myself.

Scoring:
Items 2, 9, 10, and 12 make up the agency subscale.
Items 1, 4, 6, and 8 make up the pathway subscale.
Researchers can either examine results at the subscale level or combine the two subscales to create a total hope score.

APPENDIX L

Revised Adult Attachment Scale

Adult Attachment Scale (Collins & Read, 1990)

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5

Not at all characteristic of me — **Very characteristic of me**

(1)	I find it relatively easy to get close to others.	_____
(2)	I do not worry about being abandoned.	_____
(3)	I find it difficult to allow myself to depend on others.	_____
(4)	In relationships, I often worry that my partner does not really love me.	_____
(5)	I find that others are reluctant to get as close as I would like.	_____
(6)	I am comfortable depending on others.	_____
(7)	I do not worry about someone getting too close to me.	_____
(8)	I find that people are never there when you need them.	_____
(9)	I am somewhat uncomfortable being close to others.	_____
(10)	In relationships, I often worry that my partner will not want to stay with me.	_____
(11)	I want to merge completely with another person.	_____
(12)	My desire to merge sometimes scares people away.	_____
(13)	I am comfortable having others depend on me.	_____
(14)	I know that people will be there when I need them.	_____
(15)	I am nervous when anyone gets too close.	_____
(16)	I find it difficult to trust others completely.	_____
(17)	Often, partners want me to be closer than I feel comfortable being.	_____
(18)	I am not sure that I can always depend on others to be there when I need them.	_____

APPENDIX M

Spiritual Well-Being Scale

SWB Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree D = Disagree
MA = Moderately Agree MD = Moderately Disagree
A = Agree SD = Strongly Disagree

1. I don't find much satisfaction in private prayer with God. SA MA A D MD SD
2. I don't know who I am, where I came from, or where I'm going. SA MA A D MD SD
3. I believe that God loves me and cares about me. SA MA A D MD SD
4. I feel that life is a positive experience. SA MA A D MD SD
5. I believe that God is impersonal and not interested in my daily situations. SA MA A D MD SD
6. I feel unsettled about my future. SA MA A D MD SD
7. I have a personally meaningful relationship with God. SA MA A D MD SD
8. I feel very fulfilled and satisfied with life. SA MA A D MD SD
9. I don't get much personal strength and support from my God SA MA A D MD SD
10. I feel a sense of well-being about the direction my life is headed in. SA MA A D MD SD
11. I believe that God is concerned about my problems. SA MA A D MD SD
12. I don't enjoy much about life. SA MA A D MD SD
13. I don't have a personally satisfying relationship with God. SA MA A D MD SD
14. I feel good about my future. SA MA A D MD SD
15. My relationship with God helps me not to feel lonely. SA MA A D MD SD
16. I feel that life is full of conflict and unhappiness. SA MA A D MD SD
17. I feel most fulfilled when I'm in close communion with God. SA MA A D MDSD
18. Life doesn't have much meaning. SA MA A D MD SD
19. My relationship with God contributes to my sense of well-being. SA MA A D MD SD
20. I believe there is some real purpose for my life. SA MA A D MD SD